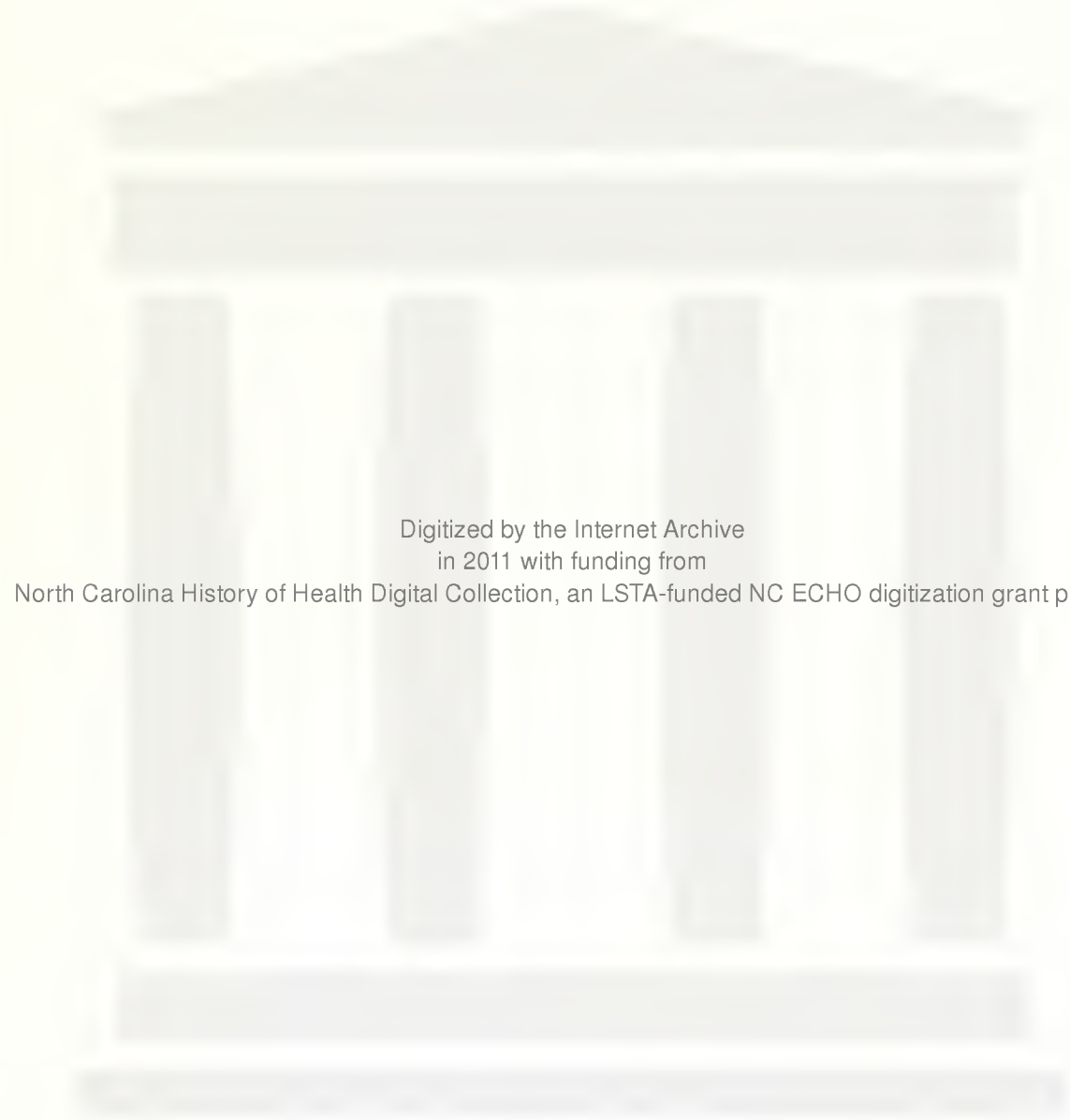

PROCEEDINGS AND REPORT

OF THE

FIRST NORTH CAROLINA HEALTH CONVOCATION

Albert F. Painter, Jr.
Ellen M. Ironside
Editors

Royal Villa
Greensboro, North Carolina

Co-sponsored by

North Carolina Health Council, Inc.

and

Office of Continuing Education in Health Sciences
University of North Carolina at Chapel Hill

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March 1976

Chapel Hill, North Carolina

FIRST NORTH CAROLINA HEALTH CONVOCATION

The Program

Tuesday, December 2, 1975

1:00 p.m. **Purpose of the Convocation**

David G. Warren, President
North Carolina Health Council
Professor, Department of
Health Administration
Duke University

1:15 p.m. **Keynote**

"An Overview of Health Needs in the South"
George H. Esser, Executive Director
Southern Regional Council
Atlanta, Georgia

1:45 p.m. **Keynote**

"Determining North Carolina's Health Care Needs"
The Honorable James E. Holshouser, Jr.
Governor of North Carolina

2:15 p.m. **Soapbox Presentations**
5:00 p.m.

Critical Areas of Health Care Needs in North Carolina

"Quality of Health Care"
M. Frank Sohmer, M.D.
President, N.C. Medical Peer
Review Foundation, Inc.

"Health Manpower"
Jim Bernstein, Chief
Office of Rural Health Services
N.C. Department of Human Resources

"Economics of Health Care"
Thomas A. Rose, President
Blue Cross and Blue Shield of North Carolina

"Health Legislation"
Ernest Ratliff, Attorney-at-Law

"Environmental Health"
F. Oris Blackwell, Associate Professor
Department of Environmental Health
East Carolina University

"Health Planning and Resource Allocation"
George M. Stockbridge, Executive Director
Health Planning Council for Central
North Carolina

"Family and Population Planning"
Thomas J. Vitaglione, Head
Family Planning Branch
N.C. Department of Human Resources

"Access to Health Care"
William F. Henderson, Director
Program on Access to Health Care

"Consumer Education in Health Care"
Lillian Woo, Director
Consumer Center of North Carolina

"Occupational Safety and Health"
John C. Lumsden, Branch Head
Occupational Health Branch
N.C. Department of Human Resources

5:30 p.m. Social Hour and Dinner

7:30 p.m. **Multimedia Presentation**

"North Carolina's Health Care Needs"
Mr. David L. Raney, Director
Medical Television
School of Medicine
University of North Carolina at Chapel Hill

8:30 p.m. **Business Meeting of the N.C. Health Council**

Wednesday, December 3, 1975

8:30 a.m. **Topic Discussion Groups**
10:30 a.m.

Quality of Health Care
Mr. William C. Parker, Jr.
Executive Director
Piedmont Medical Foundation

Health Manpower
Dr. James C. Leist, Associate Director
Northwest Area Health Education Center
Bowman-Gray School of Medicine

Economics of Health Care
Dr. Robert Diseker, Assistant Professor
Department of Community Medicine
Bowman-Gray School of Medicine

Health Legislation
Mr. Thomas W. Ross, Assistant Professor
Institute of Government
University of North Carolina at Chapel Hill

Health Planning and Resource Allocation
Mr. Larry Burwell, Chief
State Health Planning and Development Agency
State Department of Human Resources

Access to Health Care
Dr. Donald C. Hayes
Associate Dean for Community Medicine
Bowman-Gray School of Medicine

Consumer Education
Mrs. Joann Flair, Co-ordinator
Patient Education Center
North Carolina Memorial Hospital

Occupational Safety and Health
Dr. Carl M. Shy, Director
Environmental Studies Institute
University of North Carolina at Chapel Hill

10:45 a.m. 12:00 noon **Group Reports to the Convocation**

Dr. Cecil G. Sheps
Vice Chancellor for
Health Sciences
University of North Carolina at Chapel Hill

12:00 noon 12:30 **Summation**

Dr. C. Arden Miller, Professor
Maternal and Child Health
School of Public Health
University of North Carolina at Chapel Hill

12:30 1:00 p.m. **Closing Remarks**

David G. Warren, President
North Carolina Health Council

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THE CONVOCATION

"... an open forum to identify the most critical health care needs facing our state today and to offer a more comprehensive view ..."

PURPOSE OF THE CONVOCATION

David G. Warren, President
North Carolina Health Council
Duke University

You have been called together for a serious purpose: to concentrate your thoughts and ideas on the health care needs of the citizens of North Carolina. The outcome could be exciting: a new concerted effort to resolve those needs. You come here from all parts of the State and from a diversity of backgrounds and affiliations. You do not all vest the same interests nor seek the same payoff from this meeting. But we all know that health is essential to well-being. Individual members of society must be healthy human beings in order to create and enjoy fully the fruits of the American way of life. This has always been an important common goal.

The purpose of this first North Carolina Health Convocation is based on the belief that people of good will can meet together to discuss problems and jointly fashion solutions. The North Carolina Health Council exists for that end. It provides for us today a neutral ground -- a "Tent of Meeting" in the words of Carlyle Marney -- where diverse groups can assemble for a common purpose. This open forum is without the pressure of a legislative hearing or the narrowness of an academic conference. It provides equal time for both consumers and providers -- either in or out of their traditional roles -- to speak their minds on any issues and concerns about the health care needs of North Carolina.

This convocation is a time to focus on the health needs of North Carolina citizens from all angles -- as perceived by those close to the scene of health care services as well as those not close.

It is a chance to find common perceptions about what is missing in the health care picture. Is there not enough concern about health maintenance or

not enough doctors?

It is an opportunity to discover what is happening to some fellow citizens that ought not to be happening. Are there too many untreated non-paying patients or too much bureaucratic red tape in private and public reimbursement programs?

It is a time to explore the reality of what ought to be done to improve the chances of all persons for a healthier life -- infants and elderly, easterners and westerners.

It is the hope of the convenors of this convocation -- the North Carolina Health Council --- and the conference administrator--the Office of Continuing Education in Health Sciences --- and the sponsor--the Kate B. Reynolds Health Care Trust -- that four processes will occur during this program:

- identification of a wider range of true health needs than any of us were aware of before today;
- development of a sense of urgency about those problems that demand new attention;
- reinforcement of the good efforts of the many persons and organizations who are already dealing with these needs; and
- stimulation of new alliances between
  - big and little organizations,
  - individual efforts and collective (system) operations,
  - government agencies and private groups, and
  - people with ideas and people with money, all with the purpose of building a link between those with needs and those who care.

We do not expect this representative assembly to name the number one health problem in North Carolina and ask the Governor and the Legislature to solve it. A more realistic expectation is to realize the complexity of health and health care and to reaffirm a will to find the means to deal with those health needs we discuss here.

The presentations and deliberations that now follow should provide fuel for continuing talk and action until we meet again.

THE DIRECTIONS

“ . . . building a link between those with needs and those who care . . .“

"An Overview of Health Care Needs in the South"

George H. Esser, Executive Director, Southern Regional Council, Atlanta, Georgia

In 1946, back when two North Carolina scholars -- Howard Odum and Guy Johnson -- were guiding the policies of the Council as president and executive director, respectively, the organization issued a series of position papers on various issues confronting the region. One of these papers was on health and health care. As I reread that publication today and compare it to a 1974 Council report, health issues in the South do not seem to have changed very much. In 1946 the Council reported that Southerners were poorer, more likely to be malnourished, had less access to health care, faced serious environmental health hazards in their immediate living conditions and consequently were less healthy than people in the rest of the country. The Council's 1974 report on regional health care made this observation:

In 1946, the Southern Regional Council published an overview of health needs in the South. The booklet made the point that Southerners were poorer, more likely to be malnourished, had less access to health care, were more at the mercy of environmental factors, and were consequently less healthy than people living in other regions of the country. The title of the pamphlet was *WANTED: A Healthy South.* Almost thirty years later, the Council issued *Health Care in the South: A Statistical Profile.* The introduction contained the following observation:

> We began with the premise that all citizens should have equal access to health care as a basic right... But...we...knew...that poverty, rural residence, environmental conditions, and race are powerful barriers (to exercising that right). Moreover, the South...has a larger percentage of families in poverty, larger percentages of people living in rural areas, larger percentages of people dwelling in housing without adequate plumbing and larger percentages of non-whites than any other section of the country.

The findings of this publication helped lay the background research for the Council's present Rural Health Project which operates under our Task Force on Rural Development. My remarks today are based in part on the experience of the Rural Health Project which, through field work and analysis of current health statistics, identifies the health conditions of the rural South and examines alternative approaches to health care delivery. Southerners are still less healthy than people living in other regions of the United States albeit better off than in 1946. The South continues to lag behind the rest of the nation in almost every index used to measure the effectiveness of the health system, and when these statistics are analyzed in terms of the health care needs of the region's disadvantaged population, the picture becomes more grim still. For example:

> The infant mortality rate for the nation is 23.0 deaths per 100 live births. For the region, it is 25.7. For the rural South, it is 27.8, and for rural Southern blacks, it is 45.0.
>
> The general mortality rate for the nation is 9.3. For the South it is 9.4. For the rural South it is 10.4 and for rural Southern blacks, it is 11.2.
>
> Nationally, 13.8% of the population is limited in activity for health reasons. In Southern inner-cities, the figure is 14.1%. And in rural areas, 15.8%.
>
> Nationally, the population experiences 6.6 days of bed disability per person per year. In Southern inner cities, the figure is 8.4 days. And in the rural South, 7.4.
>
> Nationally, the population experiences 16.8 days of restricted activity per person year. In Southern inner-cities, the figure is 19.1 days. In the rural South, 19.4.

And I could cite many other statistics which show the difference between the health status of the nation and the South. The problem with statistics, of

course, is that we cannot easily see the men, women, and children who actually represent the difference. But the basic point is clear. The present health care system responds inadequately to the health needs of the people in this region.

Any analysis of the reasons for this failure must begin with the recognition of an essential fact. Health status and health care in the South are closely correlated with the income levels of Southern people. Large numbers of Southerners are poor -- over 20 percent of the population of this region lives below the poverty level and in this recession the numbers rise daily. One obvious result is that millions of Southerners are effectively denied access to adequate health care simply because they cannot afford it. Further, for many Southerners factors which seriously affect health are an integral part of the environment; for example, substandard housing, impure water, and inadequate nutrition. It is difficult to accept, but over 11 percent of all housing units in the South still lack adequate plumbing facilities, and in many small rural counties with 35 percent or more poverty population, 35 percent of the housing units lack adequate plumbing.

Dr. Raymond Wheeler, of Charlotte, former president of the Southern Regional Council, wrote in 1971, "In the modern world, housing, nutrition... sanitation...clean water...have improved health conditions more than all the hospitals and doctors combined."

Dr. Wheeler articulates the basic goals without which we can never hope to have a healthy region. But the scope of his concern should not discourage us from attempting to remedy specific failures in our present system of primary health care.

A series of barriers -- many of them inherent in the medical care

system -- impedes access to adequate health care. This is particularly true for people living in rural and inner city areas -- and it is especially true for the poor. The maldistribution of physicians is a primary example. Although the supply of physicians is not a pressing problem at the national level, the quantity and location of physicians is an issue of regional concern. The number of patient care physicians per 100,000 population for the United States is 133. The corresponding figure for the 13 state South is 103.* The shortage of physician manpower assumes more dramatic proportions when these statistics are examined on a rural/urban basis; Southern counties not in metropolitan areas have only 60 patient care physicians per 100,000 people. For rural counties with over 35 percent in the poverty population, the ratio is 44 per 100,000 people. The pattern also applies to metropolitan counties with large numbers of poor people. In metro counties with less than 15 percent of the people living in poverty, the number of patient care physicians per 100,000 people is 130. The corresponding figure for high poverty metro counties is 57. And because the medical care delivery system revolves around the physician, the distribution of other medical professionals follows a similar pattern.

The trend toward medical specialization has further contributed to the geographical maldistribution of health practitioners. For a number of

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* *The 13 state South referred to here includes the eleven states of the old Confederacy--Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas and Virginia--plus Kentucky and Oklahoma. In other places in this paper statistics are cited only for the eleven-state South and in yet other places for the Census South which in addition to the 13 named above includes Maryland and West Virginia. The reason for the distinction is the different geographic patterns used by various sources to collect data.*

reasons medical specialists are drawn to urban areas, particularly the more affluent suburban fringe. Hospital services are more available, back-up services are more accessible and the patient base is larger. The increasing number of specialists has contributed to the shortage of primary care physicians. In 1931, 75 percent of all physicians in the United States practiced in the primary care field. By 1967, this figure had been reduced to 39 percent. This is especially important since the great majority of a patient's health care needs can be treated by a general physician.

For rural people, the problem of physician maldistribution is further complicated by the scarcity of available support services. Even if a doctor is available, patients may be forced to travel long distances for specialist referrals. Fewer laboratory services are available to rural practitioners. Mental health services are scarce. And although the number of hospitals in the South is generally on par with that of the rest of the country, many of these are small and inadequate county hospitals with limited equipment and services. Less than a quarter of all short-term general hospitals in the eleven state south have organized outpatient departments, despite the need for ambulatory health facilities.

In addition to being less widely available to residents of rural and inner city areas, health services are generally less accessible. Few rural areas have any type of public transportation system and, in urban areas, the system too often is not designed to make access to public facilities easy. Private transportation is beyond the means of many poor people regardless of where they live. Lack of transportation is unquestionably an important problem in medical emergencies, but it is also a significant factor in non-emergency situations. Access problems tend to deter the use of preventive and health

maintenance services and too often encourage patients to seek medical services only in crisis situations.

The problem of unavailable and inaccessible health care for many Southerners is compounded by health care costs. Staying well costs money. Being ill costs more. And in 1975, medical care costs more than it ever has before. In 1969, expenditures for health care in the United States totaled $60 billion. By 1973, the figure was $94 billion. In the past two decades each person's average annual health bill has grown from $78 to $441, a 465 percent increase over the 23-year period.

Higher prices account for nearly half of the growth in personal health expenditures. In a region where 20 percent of the population lives below the poverty level, these rising costs are beyond the means of a large number of the population, as are outlays for third party coverage. For example, people living in the South are less likely to have hospitalization insurance than residents of other areas. Non-metropolitan Southerners have the lowest hospitalization coverage of any group. In addition, restrictive state regulations make many people unable to participate in publicly financed programs to the degree that their income levels would warrant.

Both the health needs of the region and the barriers to meeting these needs are clear. The question is: How has the nation responded to these needs? The federal government has responded with a variety of programs ranging from support of biomedical research to the construction of health facilities. Federal health expenditures have increased faster than the federal budget as a whole. In 1974, federal health expenditures accounted for 12 percent of the total federal budget compared to 9 percent in 1969.

The volume and scope of all government health programs is considerable,

so I will concentrate on several of the major programs dealing with the financing and provision of medical services.

Nowhere is the government's failure to formulate an adequate response to the health needs of the region more apparent than in the area of medical care finance. Some statistics compiled by Dr. Karen Davis of the Brookings Institution illustrate dramatically the enormity of this failure. Dr. Davis calculates that if federal funds were distributed on the basis of needy people, such as the elderly and the poor, an additional $2 billion dollars in federal monies would go to the fifteen state or Census South.

The largest of the health care financing programs, of course, are Medicaid and Medicare, both specifically designed to reduce the financial burden of high medical costs for low income and elderly citizens. Both programs have been more severely compromised in the South than in the nation. Medicare payments for physician services per enrolled person are 60 percent higher in metropolitan counties with a central city than in non-metropolitan counties, and twice as high for all elderly whites as for elderly blacks in the Census South. In addition, the $60.00 deductible and the $80.00 premium required for physician services creates a special hardship for elderly people in this region, where poverty rates for families headed by an elderly person are twice as high as in the nation.

The picture is even worse for Medicaid than for Medicare. Though 45 percent of the nation's poor live in the 15 state South, only 16 percent of Medicaid dollars are spent here. A partial explanation of this disparity lies in the structure of the program and its implementation in the region. Furthermore, the optional services offered by most southern states are limited. In fact, southern states have been reluctant to fully implement even mandated

services, such as transportation and early periodic screening, diagnosis and treatment of children under 21. Eligibility for Medicaid is limited and dependent on eligibility for public assistance in all but two deep South states. Unquestionably, these severely restricted eligibility levels are responsible for the fact that the program fails to reach more than one-third of those living below the poverty level in every deep South state. In fact, in six Southern states, only one poor child in ten is included in the program. The limited concept of need built into most Southern Medicaid programs is reflected in expenditures. Dr. Davis has shown that average Medicaid expenditures per recipient in the South in 1972 were $287, compared with $344 nationally. Average expenditures per poor person were even lower -- $82, or 35 percent of the national average of $232 Medicaid expenditures per poor person. In addition, there are wide disparities in expenditures by race; white recipients receive twice the Medicaid payments received by black recipients in the South.

Inadequacies in the Medicaid program have recently been compounded by a series of Medicaid cutbacks throughout the region. The present formula for financing Medicaid requires states to assume over one-third of the cost of the program. Partly as a result of the recession and partly as a result of a new wave of anti-welfarism now sweeping the country, many states -- including nine of the Southern states -- have chosen to enact sweeping cost-saving measures, some of which are designed to save money simply by decreasing utilization. Georgia is now seeking to require co-payments on drugs, and HEW has granted its request to impose additional co-payments for physician services and hospitalization. For the moment this action, however, has been delayed by court action. Tennessee plans to institute a 10 percent across-the-board

cutback. Because the state legislature had not appropriated adequate program funds, Alabama suspended its Medicaid program for several weeks by the simple expedient of withholding monthly eligibility cards. And North Carolina has contracted with a private firm to administer its Medicaid program under an agreement which allows the company to keep 25 cents of every dollar it saves by cutting program costs. Throughout these actions was a resentment against rising costs to the taxpayer, but in too many cases there is also a thinly disguised hostility toward the poor who actually represent the social cost of poor health in the region.

Two other major federal efforts in the health care field are the Maternal and Child Health Projects and the Community Health Center program. The South's share of funds received under the Maternal and Child Health program is more in line with the region's needs, but disparities still exist. Of all poor children in the country, 47 percent live in the South while 38 percent of Maternal and Child Health funds are spent in the region. Expenditures for the South under the Community Health Center Program, which includes funding for Neighborhood Health Centers formerly administered by the Office of Economic Opportunity, account for only 25 percent of all Comprehensive Health Center monies.

The National Health Service Corps has placed health professionals in areas of need throughout the region using a variety of service delivery approaches. The Corps' new Integrated Rural Health Demonstration grant program is also a step in the right direction. The primary impetus of the Corps, however, has been toward attracting physicians and other health professionals to areas of need through scholarships with obligated service requirements. Sufficient emphasis has not been put on the problems involved

in retaining health personnel in medically underserved areas. We have also had much difficulty in many areas of the South from organized professional societies who oppose provision of such assistance to underserved areas.

There are numerous other federal programs in the health care field with important implications for the South. I have mentioned only a few examples to demonstrate some of the inadequacies of these responses. Much of the failure can be laid to the ways in which Southern states have implemented federal programs. Many shortcomings stem from the nature and emphasis of the programs themselves. In many cases, federal health care efforts have not been tailored to the needs of the region -- especially to those areas and groups within the South with the greatest needs. Isolated, fragmented programs have been geared more toward the convenience of the health provider and often operate at the expense of the health consumer. And still there is evidence, now being documented of continuing discrimination in the health care provided to blacks and poor whites.

Although the picture I have painted is bleak, there are positive new developments, many here in North Carolina. The creation of the State Office of Rural Health Service is one example, and it is perhaps the most exciting state-supported experiment in the region.

Through this agency, first, a network of state-funded primary care clinics is being established throughout North Carolina's rural areas. Second, these clinics are controlled by non-profit corporations with community boards. Third, they are staffed by nurse practitioners recruited from the rural areas to which they return after their training. The state offers technical and financial assistance in setting up the clinics to communities in need of health personnel. Under the Area Health Education Center program, North Carolina has

established nine regional training centers throughout the state. The regionalization of medical education facilities will hopefully be a force in retaining more health professionals within the state -- especially in those areas of greatest need. Medical, dental and other health professionals rotate through the centers as part of their training. Internship and primary care residency positions are available at regional centers. The development of Family Practice Residency Programs and Family Nurse Practitioner Programs at the centers should substantially increase the number of primary care practitioners trained in the state. Leadership in the use of physician extenders, such as nurse practitioners, and physician assistants, is steadily increasing within the South. North Carolina now has three physician extender training programs: a nurse practitioner program operated through the University of North Carolina, and physician assistant and associate training programs at Duke University and Bowman-Gray.

Finally, North Carolina has made the necessary provisions in state laws governing third party reimbursement for services performed by nurse practitioners. Both Blue Cross and Medicaid will pay for such services. This procedure is not only fair, but provides a needed revenue source for small clinics staffed by these practitioners. Due to the opposition of medical and dental associations, many southern states have not taken these steps and problems have resulted in the licensing and service reimbursement of new health professionals.

These programs and projects do not solve North Carolina's health needs but they demonstrate recognition of need, willingness to experiment, and what I hope will be real momentum.

Any analysis of what's wrong with health care in the South necessarily

implies what needs to be done. I certainly hope that some needed changes are clear to you from what I have said today. But since a specific purpose of this meeting is to explore possible solutions to our many problems, I would like to share some of these ideas with you. Many of these come from the Task Force on Rural Development's Rural Health Project.

1. This country must make a national commitment to recognize the pressing health needs of its medically underserved people and to develop realistic and constructive approaches to meet those needs. It is imperative that national health policy be accountable to those living in rural and inner city areas--especially the poor.

2. We must demand a national health policy which includes not only financing mechanisms which will guarantee coverage of all people (regardless of family composition, eligibility for welfare, employment status, or any other conditions)--but also address the problems of health resources--both manpower and facilities.

3. We must work for the creation of a health resources development program sufficiently funded to target effectively on personnel who desire to locate in medically underserved communities. An essential function of this program should be to stimulate the development of innovative approaches to health care delivery.

4. We must institute supplementary programs to overcome specific barriers to improved health in medically underserved areas--transportation services, outreach services, and environmental health services, for example.

5. Because health care must be responsive to the real needs of the consumer population, we must provide for meaningful consumer participation in the planning of health programs and services. Present conditions make abundantly clear that the people of this region cannot be effectively served by a medical care system dominated by the medical provider, responsive only to the needs of the marketplace. It is equally clear that significant changes take place where there is real consumer participation.

At both a regional and a state level, there are certain other steps

which must be taken if widespread change in our health care system is to be effected, and some of these are at least underway in North Carolina.

1. Within the region and within the individual states, we must establish effective mechanisms to increase support for and encourage development of innovative/ alternative approaches to the delivery of health and medical services in underserved areas. Examples of such approaches would be nurse-practitioner clinics with physician back-up, hospital satellite facilities, and mobile units.

2. Within individual states we must increase support for and encourage development of non-physician training programs such as programs for nurse practitioners and physician assistants. In addition we must work to change state licensing procedures to allow the optimal use of these health professionals and to ensure direct reimbursement of these health professionals and to ensure direct reimbursement for services they provide under government health programs.

3. Within individual states we must work for changes in the medical training process. Medical schools should emphasize the training of physicians and other health professionals specifically for rural and inner city practice.

So the problems are complex -- access, availability, finance, the living environment, from housing to nutrition, combined with limits on resources. And improving health status requires the cooperation of a complex range of institutions, as well as determined leadership. North Carolina has a history of leadership in health care in the South, but the task remains formidable, one to which each of you must give priority and commitment.

"Determining North Carolina's Health Care Needs"

The Honorable James E. Holshouser, Jr.
Governor of North Carolina

I am delighted to be able to participate in a program that can mean so much to the people of North Carolina for many years to come.

This convocation has been called at a time when health care delivery is the concern of many North Carolinians and many Americans. I think it is safe to say that this whole field is in a state of flux right now. We are confronted with many questions, ranging all the way from the future of medical malpractice insurance to the basic question of how much responsibility we want to turn over to government in helping us take care of our medical needs.

This conference will center on some of the most important issues -- health planning and resource allocation; family and population planning; the economics of health care; quality and cost control; health manpower; health legislation; environmental health; and access to health care.

You've come from a variety of walks of life to participate in this convocation. You bring a variety of interests and, yes, biases, to these discussions. You've come to express your ideas and viewpoints and, more importantly, to hear the ideas and viewpoints of other people.

I would urge each of you to speak openly and honestly, especially about the problems you have faced or that you can see on the horizon. Only with this kind of frank and full discussion can we expect new and constructive ideas to come forth from this convocation.

I think it also would be worthwhile for us to fully explore at this convocation and, I would hope, on a much wider scale, the many misunderstandings that exist today in the whole area of health care. And, I think it is proper for us to face the fact that there are many problems that we

simply cannot expect the government to solve for us.

There are, of course, areas which call for government solutions and government action. There are some areas in which government would be failing the people if it did not attempt to seek solutions.

The topic I have been asked to speak on today is "Determining North Carolina's Health Care Needs." That is a subject in which I have been heavily involved for the past three years.

There's no question that we have come a long way. We're a lot better off than we were 50 years ago in terms of the life expectancy of the average North Carolinian. Advances in medical knowledge, in technology, in water treatment, and a variety of other things, have combined to make it possible for many of us to have longer, healthier lives.

But this does not mean, of course, that we still don't have many health care needs in North Carolina.

One of the most important benefits of a statewide political campaign is that it gives the people the opportunity to tell the candidates about their needs and their problems. In 1972, we heard from the people of North Carolina that one of the most serious problems facing our State was the lack of access for thousands of people to primary medical services.

At that time, more than 43 percent of our physicians were concentrated in six of our 100 counties. These were generally our biggest counties, but they still represented only 20 percent of our State's population.

When we took a look at the primary care physicians under the age of 60 who were practicing in North Carolina, we saw that we had 60 counties that had a ratio of one primary care doctor to more than 4,000 people. To many medical experts, a ratio of more than 3,000 people to one primary care physician is unacceptable.

So we had a problem, and we knew it. The difficult question facing us was: What are we going to do about it?

We have known that despite the rapid growth and industrialization that have taken place in recent years, most of our people still live in smaller towns and rural areas. According to many surveys, most of them had rather be there than in a big city. In many ways, this is a blessing.

But we have also known that if we are going to keep it that way -- if we are going to keep our population distributed and avoid the hazards and horrors that come when cities get too big and unmanageable -- then there are certain things that have to happen.

One of these things is adequate health care and medical attention for people living in rural areas and small towns.

In 1973, I went before the General Assembly to deliver a special message on health care delivery. That message set forth a plan to meet head-on this serious problem facing our State.

First of all, we realized that State government could not solve this complex problem all by itself. So we developed a strategy around those parts of the problem that could most appropriately be addressed by the State.

We also felt that the approach North Carolina should take toward this problem should be realistic, comprehensive and have the strong support of the health professions, our public and private medical schools and the leadership of State government.

This combined leadership has been the single most important ingredient in the development of our plan -- a plan to place primary health care within reach of all the people, wherever they may live.

It is a comprehensive plan, and it is a realistic plan. It is an imaginative plan and an innovative plan. The problem of access to primary

health care is a world-wide problem, one that exists in many, many countries as well as most of the United States. Our plan has attracted attention from other states all across this country. Officials of the U. S. Department of Health, Education and Welfare have come to North Carolina to see what we are doing, as have representatives of congressional committees seeking solutions to this and other health care problems.

Our plan has two major components that complement each other. One focuses on the providers of health care -- the supply side of the equation. The key emphasis of this component is the decentralization and regionalization of the undergraduate, graduate and postgraduate training of health professionals, especially primary care physicians.

This is the Area Health Education Center Program. Originated by the University of North Carolina, it has grown from its infancy to a statewide system in the last two years.

Working through nine regions covering the entire State, this is a program that we expect to significantly influence the quantity, the geographical distribution, and the retention of physicians and other medical personnel in rural communities throughout North Carolina.

The AHEC program will become increasingly important in deciding at the local level what types and amount of health manpower are needed, in training this manpower in the regions as often as feasible, and in providing continuing education at the nine area centers for all health providers in that region.

One of the major goals established for the AHEC program was that 300 new primary medical care residency positions would be added between 1974 and 1979. Already, 184 of these residencies have been developed, so we're well ahead of schedule. By 1980, primary care residency training programs will be

under way in all of the nine AHEC regions.

Every dental student and every pharmacy student at the University of North Carolina will spend part of his or her training in one of the nine AHEC programs. By 1980, substantial amounts of the clinical education of UNC medical students will be taught outside Chapel Hill, and in every part of the State.

Right now, family nurse practitioner training programs are in operation in three widely scattered locations -- Greenville, Chapel Hill, and Asheville. These are in addition to the physicians' assistants training done at the Bowman Gray and Duke University Schools of Medicine.

The Area Health Education Center program is based on the premise that health professionals are more likely to locate in areas in which they receive their residency or other post-graduate training.

Another major thrust of this program is that all of our health professionals will be provided with high quality programs of continuing education, whether they live in a town of 500 people or a city of 300,000.

We know that one of the most important needs of any health professional is the ability to keep up in his or her profession. In the past, it was extremely difficult for physicians, nurses, and dentists outside of metropolitan areas or centers of medical education to get access to a continuing education program. In many instances, this was the major factor in their decisions not to practice in our smaller communities. The Area Health Education Centers are rapidly developing new and innovative continuing education programs for the health professionals in their regions.

As I mentioned earlier, the North Carolina plan has two major components. While the AHEC program focuses on the supply of health care

providers, the second component of our plan gives attention to the communities that are most in need of medical care services.

Another key component in that special message to the legislature in 1973 created an Office of Rural Health Services. This new State office was given the job of giving a helping hand to our smaller communities that need and want to bring primary health care within reach of their people.

In establishing this program, we knew that there is no one single solution to the access problem. We knew that the State could not dictate to the various communities what they would and would not do. Our idea was to put the State of North Carolina in a position to assist the communities in designing and implementing appropriate, realistic delivery systems to meet their own particular needs.

The know-how necessary to carry out this task was assembled in a technical assistance staff that was experienced in community organization. This staff was cross-trained in specific skills in such areas as clinical and business assistance. We have backed up this group with other staff members who have very specific skills, such as facility design, equipment needs and medical records.

The Office of Rural Health Services has four major resources.

First, the Rural Health Centers Program provides funds to help communities develop their own health centers.

The Physician Locater Assistance Program recruits and assists in the placement of primary care physicians in communities which need them and can support them.

The National Health Service Corps liaison program makes our technical assistance staff available to facilitate the development of appropriate sites

and recruitment of National Health Service Corps personnel for those communities.

And, finally, the Educational Loan Program provides incentive loans to students who will agree to practice in areas of health care shortage.

The major emphasis of the Office of Rural Health Services is the establishment of a network of community health centers. These centers are organized to provide the great majority of a person's primary care needs at the local level through the use of physician extenders, such as family nurse practitioners and physicians' assistants, who work within the framework of a carefully organized system of medical care delivery.

For the patient, his local Rural Health Center is his point of entry into a total system through which he can be referred to a back-up physician, to a hospital, and back again to the local center without losing the continuity of care that is so essential.

The foundation of this program is the community itself. Before a community is selected as a site for one of these centers, that community has to demonstrate that the center has strong and broadly-based support. This program is designed to work in those communities in which the people are willing to put forth the time and the money to develop their own health program.

After the initial State grant to get them started, the centers are expected to support themselves financially with the fees collected from the patients.

Ten of the centers have been opened, and by the end of next year we expect to have 15 in operation and five more under development. Since our physician recruitment program began, 16 physicians have been recruited and

our goal is to recruit a total of 50 by the end of 1976 to serve in rural areas.

The total impact of this rural health program by then will be to provide access to quality medical care to 210,000 North Carolinians who, before these programs were begun, could not obtain medical services without traveling long distances.

We are excited about the plan we have developed to overcome this serious problem. The North Carolina program is working -- from both ends of the spectrum. On the one hand, through the AHEC program, we are increasing the number of health professionals needed to serve our people. At the same time, we are helping communities develop programs that will provide their people with quality medical care.

There is no doubt that North Carolina has become the front-runner in the nation in developing realistic but imaginative strategies to solve this problem.

The AHEC and Office of Rural Health Assistance programs grew out of a need -- a real need that was felt by many people and that was clearly brought to our attention by the people of this State.

Problems faced repeatedly, and often tragically, by the people of North Carolina also were responsible for the creation in 1973 of our Office of Emergency Medical Services. This office was given the job of improving our capability to effectively handle emergencies, no matter where they might occur.

Because of the nature of the problem, it was recognized that we needed a comprehensive program, one that covered all facets of emergency care, including facilities, informative systems and transportation.

We started out to build a solid foundation by emphasizing training and evaluation at the outset. So far, more than 7,000 medical technicians have been trained under this program.

Working hand-in-hand with this State program is an effort sponsored by three of our private foundations in North Carolina to help hospitals establish full-time qualified services in their emergency rooms.

We realize, of course, that North Carolina, like any state, has more health needs than it has resources to meet those needs. This means we have to set priorities, and that isn't any easy job.

We know that even though we have made a major commitment to improving the access of primary care services to the people of North Carolina, we have only addressed part of the overall problem.

For example, there is the need to educate people, to help them become more aware of what they have to do to take care of their health and to give them a better understanding of the health care delivery system that is available to them.

There is the question of paying for medical care and the problems that this presents to both the patient and the provider. This has become a national issue that is now being debated in Congress.

The complexity of modern society has a tremendous effect on the health of our people. We have the technological know-how to do almost anything ... we can even transplant a heart.

The question we face is whether we have the will to meet our challenges. My own experience with the development of the North Carolina plan for meeting our State's number one health care problems has convinced me that we will be able to meet these challenges as they come.

It won't be easy, but with people like you -- and with programs such as this one today -- we can make it possible for every person to get the health care he needs ... when he needs it, where he needs it, and at a price he can afford.

THE PRESENTATIONS

“ . . . to speak their minds on issues and concerns...”

"Quality of Health Care"

M. Frank Sohmer, M.D.,
N.C. Medical Peer Review Foundation, Inc.

Ladies and gentlemen, it is a pleasure to be with you. I've got a hard couple of acts to follow -- Governor Holshouser and Mr. Esser. I think it's demonstrated that the television people left. I'm glad you stayed. Thank you.

It seems appropriate that the marquee out front indicates that we are here meeting with the funeral directors. The name of our game is to put them out of business. That is what it is all about and I hope you will come up with the answers as to how we can do that.

The title of my presentation is,"The Quality of Health Care." I will start off early by saying I can't define that, so we won't talk about it. I really am going to talk with you about PSRO, the Peer Standards Review Organization and the North Carolina Medical Peer Review Foundation and about the Medicaid Program. I want you to be aware of what's going on in this area because it does address itself to necessity of health care. I hope that PSRO will have some impact on access, and I'm certain that it is going to have some impact on quality, in spite of the fact that I can't define that for you very clearly.

The North Carolina Medical Peer Review Foundation was developed in 1973 because of the federal mandate of Public Law 92-603 (in 1972) which you may know as the PSRO, or the Bennett Amendment to the Social Security Act. At the present time in North Carolina, there are no PSRO's that are active although we have one planning grant in Winston-Salem in Area Two west of here. The Piedmont Medical Foundation has been active in Winston-Salem and the surrounding twelve counties and has been eligible to be a qualified, conditional, operational PSRO for the last twelve months. However, the government, as is

too often the case, has failed to fund the program adequately, so that we are at the mercy of that problem at this time. We are hopeful that in the near future the Congress will make up its mind that it does need to fund this legislation because it can be meaningful to health care, both as to quality and cost containment. Though the law itself speaks about quality for forty pages, the direction of Congress and the intent of Congress is cost containment.

The North Carolina Medical Peer Review Foundation was instrumental then in establishing, in the eight designated PSRO areas in North Carolina, physician corporations -- corporations which are active and have a viable membership. There are six areas in North Carolina at the present time which could become conditional, operational PSRO's within this month, areas which are actually carrying on review. In addition, in response to a request from the state made a year ago, we established an on-site review program to promote quality of care in the long-term care institutions -- that is, in the skilled nursing facilities and the intermediate care facilities. We do this with Medicaid patients,via review teams,sending in a social worker and a nurse with each team and bringing in an area physician to review all of the Medicaid patients who are there. This originally started,as is often the case, as a learning process for us because we had no background. Now we think we have developed a very meaningful program. Eighteen months later, we are actually examining patients and making recommendations as to care, medications, diagnostic studies, and the like, to their attending physicians. We feel that we are having an impact on better care, or quality of care, in these nursing homes. More recently, we have established a simple bed registry system for these nursing homes. We keep a running roster in Raleigh at the Foundation's

offices, of available beds in the long-term care facilities because locating beds has been a problem for people, whether they are in the Social Services Department in the county, or in the hospital, or an individual physician who needs to find one.

In January of this year -- and I must give Secretary Flaherty a great deal of credit for much of this -- we signed a contract with the state and developed a hospital admission review program, which is referred to as HARP. Again, this is to promote the quality of care received by Medicaid patients, this time those in acute care institutions, that is, the acute hospitals. This program utilizes the area organizations and none of the review is done in Raleigh. It's done in Winston-Salem, Chapel Hill, and Charlotte, or wherever the care is being given. These area organizations are subcontracted by the North Carolina Medical Peer Review Foundation. They carry out the review at the local level which is the only reasonable way it can be done. These corporations utilize local physician advisers to discuss problems with the patient's attending physician during the patient's confinement. This is not the usual retrospective review. We look at the patient within 24 hours of admission, we determine the average length of stay, and then we follow that patient's course during the hospitalization. We've carried out, during the time of this program, some 30,000 reviews. We feel that we have had a significant effect in several areas. We view this as an educational program. We don't look at it in the sense of denying anyone access to care. We do not feel that we are in the process of throwing anyone out of the hospital who needs to be there and are not interfering with the private physician in his care of the patient. Yet while we have been performing these 30,000 reviews, we have had a significant reduction in length of stay in the hospital for

these patients. Consequently, there are going to be reduced costs. We feel that this is beneficial to all of us. I'm a taxpayer, as well as you, and I'm most interested in this. I further believe that everyone is better off out of the hospital. I think we all are enjoying being here this afternoon, rather than being in bed in a hospital someplace. I just don't believe in protracted and unnecessary hospitalization and I think that there is an educational effort in all of this for the patient, for the citizen, for the physician, and for all health care providers.

Ours is a very broad program with tremendous potential. We have now completed two contracts with the state and are currently in a tripartite contract with the state and with Health Application Systems, the private corporation with a prepaid contract for the Medicaid program. We've got difficulties in trying to implement anything that big. It's increased 25,000 since the contract was signed, from 312,000 people to 337,000. Eligibility, as was mentioned earlier, remains a problem. It's something many of you may be familiar with, and it's something the state is working on. The Foundation, in developing this contract, is now involved in an intricate system for monitoring the quality of care for the ambulatory, or outpatient services, rendered by all health care providers. Computer-generated data are being utilized to perform retrospective reviews of the care that is being provided. We are also going to look at those patients who are, if you will, "professionally shopping." We want to demonstrate to those people who are under the care of seven physicians and two chiropracters, or one podiatrist and five physicians, or however you want to divide it up, that they are not getting good care. We can demonstrate this in the drug analysis. Often, they are taking drugs that conflict with each other and are potentially hazardous to their health.

But we are not interested only in the overutilization. We are implementing in this program an underutilization module, and we're looking for those patients who come out of the tuberculosis sanitorium, who are given medication and are told to report back, and who are never seen again. We are looking for those diabetics who are brittle, who are difficult to control, and who, through lack of adequate ongoing care, continue to show up in the hospital. Each time they reappear, we can plan on their being there an average of 18 days, and this is going to cost the Medicaid program at least $3,000. If we can see these people every couple of weeks, or every month, it is better because, as we maintain their health, we prevent unnecessary hospitalization. So, there are many things that we are looking at and implementing in this program. The contract is, in fact, a total review of the Medicaid program as such.

As I have already said, I cannot define quality. I've seen people try, and after many, many attempts, they have come to the same conclusion that I have. You've got to get into the question of necessary health care, the question of comprehensive health care, and a lot of other definitions which I really don't think are pertinent to what we are talking about. The important thing is to see that people get the best care available when they need it, and I think that is what it's all about. PSRO cannot be implemented in this state until federal funds are forthcoming, a problem to which I referred earlier. At the present time, the Congress is apparently going to allot about $45,000,000 to carry out the review in the United States for Title V, Title XVIII, and Title XIX. Now this is for child and maternal welfare and the Medicare and Medicaid groups of patients, so you can see, in reviewing 30% of the hospitalizations that occur, $45,000,000 isn't going to touch it.

As a result, I do not expect any PSRO to be implemented in North Carolina this year.

We've taken the position that we like the idea of peer review, and that we want to do this. Consequently, we have gotten involved in it through the Medicaid contract. However, we feel that not only government patients should be involved -- we feel very strongly that peer review is good for all patients. I do not think that we should, if you will, discriminate against those patients who are supported by either state or federal funding and simply review them. I think that every patient who comes into any facility could be looked at. There are some who come in and out and don't need to be looked at, but I think that all of us could benefit from an overall review program. The private insurance industry is interested in implementing this, and we are talking with them. We are hopeful that during the course of the next year this can be a much broader program in North Carolina. As such, we see it as improving the quality of care. We see it as cost containment. We see it as a significant educational program. I want to emphasize the educational program because this is important. We find, for example, that when we go into the nursing homes, the nurses and the staff, the LPN's,the aides, all of them are really glad to see us. It is an educational experience for them to review patients with physicians, a nurse, and a social worker in order to better understand a patient's overall problem. We've found this to be very beneficial. In fact, we have many testimonials from physicians, thanking us for suggestions that we have made in these reviews.

I certainly would agree with some of the remarks that have been made today. Changes are imminent in the health care delivery system. As you know, there are multiple hearings in Congress in progress at the present time. And every year there are several thousand pieces of legislation pitched into

the "hopper" up in Washington.

I was interested to read in *Parade* this week that, in the Cambridge Survey, 23% of the people surveyed wanted a completely nationalized health system. I would like to interpret that as meaning that 77% of the people don't but I am not sure what it means. At any rate, the survey indicated that 13% wanted no change and about 64% felt that some type of support or change was needed, but nothing as broad as complete nationalization.

I want to say that no reasonable physician can object to any suggestions that people make which are beneficial to the health care delivery system. We welcome help from anyone, I don't care who it is. But when government rules and regulations begin to interfere with the patient/physician relationship, then you raise the ire of the physician group. We are as interested as anyone in the overall health care of our citizens. Yet I've not been enthusiastic to date over any of the government attempts to answer these problems. I believe in the private sector and I will continue to support that. I hope you will come up with some good ideas for us to implement.

"Health Manpower"

James Bernstein, Office of Rural Health Services

What I am going to do today is not try to give my opinion of what North Carolina's health manpower needs are and will be in the future but, rather, to use the next few minutes to raise three questions that I feel need to be in everyone's mind when they involve themselves in health personnel policy planning. Hopefully, these generic questions will contribute to tomorrow's discussion sessions on health personnel needs.

The first question is: How much and what kind of health personnel do we need?

Today there are more than four and one-half million people working in the health field, representing 200 different professions. Our country, when it sets its objectives clearly, has the ability to do whatever it needs. Within the last ten years, the decision was made to expand our health personnel pool. New legislation was and is being introduced at the federal and state levels to provide the funds to achieve this objective. For example, in 1960 there was one active physician for every 717 people in the United States. It is projected that by the year 2000, there will be one physician for every 350 people. It is anticipated that the supply of allied health personnel will increase four-fold between 1970 and 2000. Physical therapists alone are projected to increase in numbers from 7,300 in 1970 to 58,000 by the year 2000. Put another way, we will go from one physical therapist to 17,738 people in 1970 to one physical therapist to 4,554 people by the year 2000. Presently there is one certified laboratory assistant for every 30,579 people. It is projected that by year 2000, this ratio will be one to 3,475.

These are just a few examples of projections of where we will be in terms of gross numbers of health personnel seeking employment by the year 2000. We have geared the system to produce health workers and it will.

The second question is: What will be the cost of this increase in health personnel? Or, put another way: How much are we willing to pay for health care, given that two-thirds of the cost of health services is in personnel?

We are presently spending 8% of our Gross National Product on health services. Given our projections for increased personnel over the next 25 years, it is not unreasonable to assume we will be devoting 12% of our Gross

National Product to health care by the year 2000. What this means to you and me is that instead of today's average expenditure of $550 per capita, we will be spending $800 per capita. Those figures represent total dollars spent. For example, General Motors spends between $125 and $150 per automobile manufactured on health insurance for their employees.

Now, more than ever before, we need to establish priorities for our scarce resources. Therefore, policies on health personnel should be viewed not only from the perspective of health needs, but in the context of the total needs of our population, whether it be for education, housing, transportation, or defense.

Question number three is: If our objective is to improve our health, how do we harness the most important manpower group of all -- the public?

I believe that more professional personnel can save some lives, decrease some disability and increase to some extent life expectancy. To what degree professional services are the answer is questionable. Over the past 75 years, life expectancy has increased dramatically, largely due to our impact on reducing communicable diseases. From 1900 to 1974, the average life expectancy from birth increased by 25 years. However, only a small percentage of this change has occurred in the last 25 years, even with our tremendous advances in medical science. It seems we have reached a point of diminishing returns in terms of overall life expectancy.

More significant to this discussion is the change in the kinds of major health problems we are experiencing today versus those of 75 years ago. The major epidemic of the seventies is cardiovascular disease, which accounts for as many deaths per 100,000 population as tuberculosis did in the nineteenth century. Other major killers are cancer, strokes, accidents, and alcoholism.

I feel most health professionals believe that the solutions to today's major health problems do not reside simply in more personal health services. Rather, they are affected by changes in life style and the environment.

Herman Somers wrote in a recent article in *Inquiry*, "It should be noted that the mortality data show a preponderant incidence of preventable causes, but generally not of the kind that lend themselves to medical 'cure.' They reflect primarily the consequences of life style and personal behavior, and portray circumstances wherein medical intervention is usually too late... It now seems that the greatest potential for improving the health of the American people is probably not to be found in increasing the number of physicians or hospital beds, but rather in what people can be taught and motivated to do for themselves, in influencing personal behavior and attitude."

I have chosen to address these questions because I believe we often confuse means with ends. Decisions on health personnel policy must be viewed in the context of the health problems we are trying to solve and the ramifications of these decisions on society as a whole. My personal work is in the organization of health services which, like financing, is greatly affected by manpower decisions and vice versa.

North Carolina, more than any other state, has systematically looked at its manpower needs and established a rational process to make manpower decisions and implement, on a local level, the educational programs required to meet these needs.

We have undertaken an effort to assist community groups, hospitals, and private practitioners to develop the health delivery systems which can make most effective use of the health professionals presently being trained by our educational system. These efforts are specifically directed toward the

underserved areas of the state to help assure an equitable distribution of the manpower being trained.

Still, we must guard against portraying the solution to our health problems, as viewed by the public, as simply a manpower question. Even with all the effort being given to this aspect, we know that there is no one solution to our health problems, whether they be associated with access, nutrition, or health behavior -- and all will take time. Yet, I think Victor Fuchs in his book, *Who Shall Live?*, made a very astute observation when he wrote, "Ours is an age of 'great expectations' and little patience."

"Economics of Health Care"

Thomas A. Rose, Blue Cross and Blue Shield of N.C.

The economic point of view is rooted in three fundamental observations about the world:

- first, that resources are scarce in relation to human wants;
- second, that resources have alternative uses;
- third, that people do indeed have different wants. Health is often thought of as "the most important goal" but this does not accurately describe human behavior. Every day in many ways (such as overeating or smoking) we make choices that affect our health, and it is clear that we frequently place a higher value on satisfying other wants.

Given these three conditions, the basic economic problem is how to allocate scarce resources so as to satisfy human wants. That is a simple and straightforward statement; however, its application to the field of health is an arduous task. It is not my intent to bore you with demand and price elasticities and inelasticities, Phillips curves, arcelasticities, and

econometric models. I do intend to show some of the factors that cause health care costs to be what they are today.

The Nation's $104.2 billion health bill in 1974 was a function of a number of factors, including the price of services and supplies, per capita utilization, supply of facilities and health manpower, and the quality and quantity of inputs. Although the contribution of each factor varies according to the category of expenditure, price increases have historically been the major contributor to rising expenditures. I will mention other factors contributing to our national health bill later.

Beginning in August 1971, the health care industry was subject to mandatory economic controls under the economic stabilization program that remained in force until April 30, 1974. Although controls on the health industry were officially in effect for ten months of fiscal year 1974, medical care prices began to accelerate several months before the expiration of the program. As a result, the last half of 1973 was characterized by unusually high rates of increase.

The increase for 1974 in total health care spending was 10.6%, slightly higher than the revised annual increase of 9.1% for 1973 when mandatory economic controls were fully in effect for the health industry. Despite the acceleration, health expenditures remained at the 1973 proportion of the gross national product -- 7.7%. Public spending for health services increased twice as fast as private, mainly because of the expansion of the Medicare and Medicaid programs. Third parties financed an estimated 65% of all personal health care spending, with the government's share at 38% and private health insurance at 26%. Direct out-of-pocket payments in 1974 amounted to $149 per person, compared with $142 the previous year.

The $104.2 billion national expenditure for health care in 1974 was an overwhelming increase from the $12 billion spent in 1950. Health care costs as a percent of the GNP were 7.6 in 1971, 7.8 in 1972, 7.7 in 1973, and 7.7 in 1974. Concomitant with the increase in actual dollars devoted to health, the cost per unit of health care service has been rising. The health economy has been even more inflationary than the general economy when matched against all other items in the Consumer Price Index.

The subject of the "Economics of Health Care" is a very difficult one, but I will attempt to treat the subject fairly without insulting any economists in the audience. It is no longer a question of "are prices rising?" but "will prices ever level off?" and "what can and should be done about the contributing factors over which we have some control?" My intention today is not to solve problems, but to state them in a way that will invite your recognition and professional debate. Hopefully we all can learn together.

Recent inflationary trends have reduced the purchasing power of the medical and health dollar of both the government, private health insurance companies, Blue Cross Blue Shield Plans, and the consumer. This erosion is particularly alarming because the current escalation in medical care prices is the steepest in history.

The most recent wave of inflation was augmented by an agonizingly persistent series of inflationary "accidents": a food accident; a petroleum accident; the suppression and then the highly energized release of price pressures by the direct controls mechanism; the collapse of the Bretton Woods monetary structure, involving a massive growth of international liquidity in the last-ditch defense of the dollar; and then a powerfully

stimulative (to the United States) devaluation of the dollar. The impact on our domestic economy, to include health costs, is history.

Complicating the picture even more is the longest period of recession since the post-depression era. Studies have shown that economic recessions tend to cause increases in health status indicators in such critical areas as infant and maternal mortality, mental hospital admissions, suicides, homicides, auto accidents, alcoholism (cirrhosis), heart disease, and cardiovascular-renal disease.

Compounding the problems of inflation and recession, or "stagflation" as it is sometimes called, is the continuing energy crisis. Energy consumption in the United States is estimated to be increasing at four to five percent per year, while the production of all energy forms in the United States has been declining or remaining stable, with little promise of improvement over the next few years. Health care depends heavily on energy sources and petroleum-based products. Because energy conservation measures must receive high priority, the health care industry cannot assume that it will be exempt from escalating costs and restrictive federal regulations in the energy area.

In summary, the relationship between morbidity and mortality and economic problems is admittedly very complex, and often perceptible only after a lag of several years or more. Now let's look at some of the leading indicators which figure prominently in the economic schema of health care.

The United States is slowly approaching a zero population growth (ZPG) where births and net-migration are approximately equal to deaths with a corresponding 1% annual growth trend. The median age is expected to rise from 28 to 29 years giving an older population distribution by 1980. ZPG plus an older population could lead to an increase in the incidence of chronic and more expensive-to-treat conditions.

Personal incomes have never been higher in this country. However, with the erosive effects of inflation mentioned earlier, the health purchasing power is diminished. It has been established, though, that the higher the personal income of an area the higher the per capita consumption of health care services.

The high unemployment rates experienced during the past two years caused Congress to debate the provision of some form of health insurance for the unemployed. Steel, auto, and other durable goods manufacturing have experienced slight upswings during 1975 but not enough to eliminate the severity of current unemployment rates. As unemployment rises, providers of health care are faced with unpaid bills which have to be passed along to the paying customers or written off.

Consumer expenditures in the United States by absolute economic necessities show dramatic increases from 1960 to 1973. Expenditures for food increased 105% from $87.5 billion to $179.4 billion; clothing expenditures increased 146% from $33.0 billion to $81.0 billion; housing expenditures increased 151% from $93.2 billion to $233.5; health expenditures increased 226% from $19.1 billion to $62.3 billion; and expenditures in all other categories increased 170% from $92.4 billion to $249.1 billion.

Aggregate expenditures in the health sector have been rising approximately 10% or more per year for each of the past eight years. All Western industrial nations for which data are available have been experiencing similar increases in recent years. For instance, in France, aggregate expenditures for health services more than tripled between 1965 to 1974, an annual growth rate of approximately 14%. Between 1965 and 1972, Sweden's aggregate expenditure increased by more than 150% -- also an annual rate of 14%.

Thus, the experience of the United States during this period has not been atypical.

As I mentioned earlier, total public and private expenditures for health during 1974 were $104.2 billion. Hospital care ranked first and accounted for $40.9 billion. That's a 25% increase over 1972. Physician services ranked second at $19 billion and a 16% increase from 1972. Expenditures for drugs and drug sundries ranked third at $9.7 billion and an 18% increase from 1972. Nursing home care ranked fourth at $7.5 billion and a 27% increase from 1972. Dentists' services ranked sixth at $6.2 billion and a 16% increase.

As the numbers of families and individuals whose incomes are below the poverty ranges increase there will be mounting pressure for more federal reimbursement for health care services. This factor accounts for the increasing role of the federal government in reducing the financial barrier to health care access.

The greatest portion of the health care dollar goes to institutional providers of health care -- more specifically the hospital. The trend toward all private rooms, the constant pressures of workers' salary demands, low occupancy rates, more sophisticated equipment all result in increases in the cost of health care received at the hospital. Over the past decade, hospital costs in the United States have been increasing at about 10% a year. Therefore, we must begin to come up with meaningful programs to curb hospital costs. Also, physicians, as the health purchasing agents, cannot be absolved of their responsibilities in this very important area.

The utilization of health services differs not only by socio-economic status but also by place of residence, with the use of services generally

higher in urban areas and in the higher income groups. There is no clear-cut relationship, however, between the number of health service providers, the actual rate of utilization, and the health status of residents in a given area.

During the past four years, from 1971 to 1974, the aggregate number of physician contacts, excluding those with hospital inpatients, has remained almost constant at about one billion contacts each year. Since the number of practicing physicians has increased by between 5% and 10% during this period, it appears that the average number of patient contacts per physician providing primary care has declined somewhat since 1971. Some part of the decline could be due partly to an increase in the average time duration of physician contacts, or to a shortening by physicians of the average number of hours devoted to ambulatory patient contacts. There is evidence from other countries, notably Canada and Sweden, that physicians tend to reduce their working hours in response to the possibility of increased hourly income. Per capita utilization of health services is one of the most significant variables contributing to increases in aggregate costs.

The most frequently used long-term indicators of the health status of a nation have been total mortality and infant mortality rates. After a decade of stable mortality rates in the United States, the age adjusted mortality rates have again shown a steady decline of 2% per year since 1968. The heterogeneity of the United States population causes other-nation comparisons to be awkward. Also, inadequate indices of health which have been developed up to this point and the difficult question of morbidity

makes health status determinations difficult.

It has been said that the health status of the United States population will be elevated only when the following are dealt with, probably as a part of a national effort:

- excessive smoking and alcohol consumption;
- inadequate or excessive food consumption;
- motor vehicle accidents -- lowering the speed limit to 55 m.p.h. has helped;
- environmental pollution;
- physical inactivity;
- diseases and injuries of the work place -- total loss to the GNP each year exceeds $9 million;
- infectious diseases;
- product safety;
- genetic factors -- Down's Syndrome, cystic fibrosis, sickle cell disease, Tay Sachs disease;
- social-psychological factors -- there are well-established associations between rising unemployment or generally poor economic conditions and increases in child abuse, crime, and among some groups, increases in suicides and homicides.

It is unrealistic to think the problems caused by these factors will be totally eliminated. They will have to be addressed if the health status of the population is to be elevated. Unquestionably, factors such as housing, nutrition, employment, education, and socioeconomic status exert a powerful influence on health status as measured by mortality and morbidity, disability, and the restriction of normal activity as a result of illness or injury.

While inflation is the primary cause of rising medical care costs (accounting for 47% of the increase) with population growth accounting for another 17%, among the many other forces accounting for the remaining 36% are the costs of malpractice claims and suits. The rise in malpractice claims has caused "defensive medicine" to be practiced.

Price rises, technological developments, improved treatment procedures, and changes in both demand and supply factors round out my brief encounter with the leading indicators in the "Economics of Health Care." Along with the others mentioned earlier, they figure very prominently.

The Medicare and Medicaid programs accounted for 80% of the overall rise in public spending in 1974. One lesson we have learned from the Medicare-Medicaid experience is that the elimination of the financial barriers to health care services causes an increase in demand. Without an associated increase in the supply of health manpower and facilities, costs for all consumers will invariably increase. Moreover, because Medicare and Medicaid usually impose limitations, both on consumers (deductibles, co-insurance, uncovered care) and providers (paying them less than the going reimbursement), their effect quite often is to restrict beneficiary access to health care.

Cost containment ranges from reducing the need for care, to increasing consumer and provider cost-consciousness, to adjusting the various possible controls on the delivery, appropriateness, quality, efficiency, and financing of care. On the more practical side, the following, in the right combinations, should also help slow down price and cost increases:

- Public Law 93-641, "The National Health Planning and Resources Development Act;"
- HMO's and Alternative Delivery Systems;

- Public Law 92-603 - PSRO;
- Better supply and distribution of manpower through Area Health Education Centers;
- BCBSNC efforts such as new hospital contracts; outpatient benefits (OP claims outnumbered IP three to one in 1974); outpatient surgery; pre-admission testing; discharge planning; utilization review (POST); COB -- Coordination of Benefits; physician charge monitoring.

It is naive to think of National Health Insurance as a panacea for the current cost and price dilemma in health care. It has been said though that NHI will improve hospitals' cash flow. National Health Insurance (including the proper role of the government) is probably the most crucial and compelling issue affecting the financing and cost of health care services, as well as the overall performance of our health care system. Although specific proposals on how NHI can best be structured and administered, questions such as how costs should be distributed and contained, what degree and form of regulation would be called for, and what spectrum of benefits should be included, remain unresolved. I hope we are finally at the point of debating the basic principles or tenets of a viable NHI program.

Currently there are three basic approaches to NHI: all government; private companies as financial and administrative intermediaries; or a combination of government and private. Catastrophic coverage appears to have the most backing at present.

We must guard against the temptation to exaggerate the payoff of NHI. While the receipt of health care services affects the prevalence and severity of illness and disability, it is nonetheless true that health care services constitute only one of many factors determining health status. Unless the

supply side is sufficient to meet the NHI-generated demand, long lines will form for the receipt of health care services. The nation's current economic condition and government budget pressures militate against new spending now for NHI.

Unquestionably, over the past two decades, the cost of health care has increased dramatically. The public, experiencing financial pressures from all sides, is becoming ever more concerned about these dramatic increases. More and more people in need of medical care are hard pressed to meet their payments, whether they pay for such care directly or indirectly through higher insurance premiums. In addition, the rising medical costs make government-financed programs more costly for the taxpayer. As the public hears predictions of $1,000 a day hospital beds, they cannot help but wonder when and where it will stop.

"Health Legislation"

Ernest Ratliff, Attorney-at-Law

I count it a happy privilege to be able to appear before you today to discuss the important matter of health care needs in the area of legislation. As you know, state legislative activity in the realm of health care has increased dramatically in the past two decades and there is no prospect of a let-up at this time. Indeed, as the American health system -- or as it has been called, non-system -- grows larger and more complex, it is likely that governmental regulatory activity will grow apace.

I doubt there is anyone in the country who would gainsay the statement that the single most critical problem facing the public with regard to health care is the matter of rising costs. Informed comment and the resulting Congressional and legislative activity has focused more generally on the

matter of cost containment than any other subject in the 1970's. Many consumers look forward to more legislation aimed at price retardation. I am a health consumer and to some extent share these feelings. Yet, as I assess the need for legislative activity in the health area, I see a still greater need which would, at least in the short run, increase the real cost of health care.

I am convinced that we cannot have the quality of health personnel we need throughout the profession and, consequently, the quality of care we need unless government does something to insure better pay for those at the lowest rungs of the health careers ladder. While pay for orderlies, aides, nursing assistants and other "low level" health personnel has risen in the past few years, it is still scandalously low. In a society where incentive is tied to remuneration we cannot expect our elderly to receive proper care if the persons who must turn them, feed them, and change their diapers are paid at a minimum hourly wage barely exceeding $2.00 per hour. We cannot expect those who must do the heavy work of carrying patients, bathing and dressing them, and assisting in the performance of menial tasks to continue to do so if their salaries are adequate to maintain only a poverty level existence. The present salary structure for these who perform these unwelcome but critical health care tasks tends to attract those least temperamentally disposed to the work they must do, causes a high turnover rate, and contributes to discipline and morale problems. Government must aid in the solution of this problem. The ways in which legislators should achieve this goal must wait upon informed study. Some means though come readily to mind: upward revision of the minimum wage scales in the health care area, special tax credits hooked to the salary scales of health providers, and incentive grants. I would point out that, in

my view, an outright subsidy of limited duration is not beyond the realm of acceptability. Of course, various combinations of these methods may provide the best solution.

While the foregoing requires that real prices rise, there are some things that can be done to help check price increase. Foremost, among these is the matter of stimulating competition in the health care field so that this most valuable check on price inflation will be available. In the area of prescription drug pricing, requiring posting of drug prices would be a step in this direction. Mandatory substitution would be another. In the area of provider supply, two things are needed. First, continued influx of money to provider and provider training schools so that the supply of personnel can be increased, and second, a stringent requirement that the beneficiaries of state aid for medical education actually serve some time in medically underserved areas. The present buy-out arrangements too frequently permit doctors enjoying the benefits of the scarce supply to omit any period of service in rural areas.

Turning to the area of quality of care, state law should prescribe a grievance procedure uniform throughout the state with respect to the quality of "hospital care" provided a patient. By "hospital care" I do not mean medical care. I mean those services provided by the hospital in taking care of the doctor's patient. Patients who wish to complain about the attitudes of personnel, performance standards, and so on should have a clearly marked route of appeal throughout the state.

There should be created a State Health Advocate's Office in the Department of Human Resources. The office should be staffed by attorneys and those in related disciplines -- health planners, health educators, nurses,

and others. The office should do such things as aid the consumer in quarrels with insurance companies over coverage and make sure that consumers have the knowledge to take advantage of federal regulations helpful to consumers such as free health care regulations.

I would add a word about malpractice law. The great scare is upon us. Sickle cell and health planning among others teach us that legislation generated by scares is bad legislation. All of us should be on guard to make sure that such things as artificial limitations on damages, a lowered standard of informed consent, and rigidified mandatory arbitration do not become part of our law. If they do, I venture to say that in a calmer and saner day, we will rue the event.

Finally, our legislature must give some consideration to defining the right to die in North Carolina. We cannot long expect to avoid a Karen Quinlan case and our legislators ought to give judges some guidance now.

"Environmental Health"

F. Oris Blackwell,
East Carolina University

May I, at the start, give you the definitions that I'm working from? "Environmental" for many people means, "that out there." Too often we don't include ourselves, and yet we are obviously a part of and not apart from the environment. Another common concept of environment is that it is air, water, and land -- period. Again, it should be obvious that environment is all inclusive and, therefore, much more than air, land, and water. As I recall, even the ancient Greeks added "fire" to the list. One way that helps in understanding the concept of total environment is to look at aspects or components of the environment. The Physical aspects are those we think of most often: water, air, land, highways, buildings, climate. But to be complete, two other

aspects must be included: the Biological Environment, which includes all living things from viruses to redwoods, and the Social Environment, which is uniquely man and his entire socio-psycho-cultural endeavor.

This way of visualizing total environment fits well with the definition of health found in the preamble of the Constitution of the World Health Organization: (Health is)..."a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Health by this definition is a positive thing; a complete "human well-being."

At this point, I'm sure many are asking the relevant question -- with such a global definition of "Environment" and also of "Health," how can priority needs be defined? The "smart" answer is, of course, "with difficulty." It is so true that we have great difficulty thinking of totalities. Almost all of our training and education leads us to focus our conceptualization, our perception processes, to an ever smaller chunk of existence. Increasingly, from kindergarten through graduate school, we are taught literally "more and more about less and less." As our perceptual "microscope" is focused to the highest power of magnification, we can see great detail of a very small area, but can see nothing of the surrounding field.

In the setting of priorities we should attempt to reverse the usual educational process and try to learn more and more about more and more. This is a pressing need in environmental health -- to develop in our midst at least a small cadre of persons who are true generalists -- a few who have specialized in the widest possible understanding of environment and health. These persons must then be a part of multidiscipline teams, including so-called lay persons and consumers as well as political leaders and technical specialists. These teams should be charged with the development of, and implementation of, plans

that speak to priority needs in environmental health in North Carolina.

I believe that one of the highest priority programs that such a team would develop and implement would be an extensive effort in environmental health education, a program to teach both public and school populations of the many ways in which environment affects their well-being, what individual responsibilities toward self and others are, and as important as the rest, to motivate them to act in accordance with this knowledge.

In closing I would like to suggest another priority area that a multi-discipline environmental health planning team might develop.

Surely air and water pollution will continue to rank high on the list of factors that impact on human well-being. It is true that we as individuals with our cars, furnaces, burning leaves, flush toilets, and garbage grinders, do contribute to this pollution. It is also true, I believe, that it is not this individual pollution, separately or collectively, that is the biggest problem. It is our corporate and institutional pollution that is of grave concern. Government agencies often assume a license to pollute. And the really tough stuff -- the PCB's, the arsenicals, the mercury, the nitrosomines, and so on -- these get into our air, our water, and us from industry. Could we ask the Boards of Directors of those industries that are putting out pollution to pipe the air from the stacks into and through their conference rooms at all times during Board meetings? Or, instead of coffee break during the meetings, that they drink untreated water (except for chlorine .02 ppm) from the river one-fourth of a mile below their factory? Very likely, they then would realize their responsibility toward their own well-being and that of others.

Indeed, I can think of other areas of concern. The question could be asked as to why an estimated 300,000 persons suffer from a food-related illness

each year in North Carolina? Or, what can be done to reduce the more than 100 cases of tick-borne Rocky Mountain Spotted fever that occur each year in North Carolina? (There are only five cases per year in the eight Rocky Mountain states and only one state, Virginia, has more.) In 1974 there were about 1,000 cases of infectious hepatitus reported in North Carolina -- about 80 cases per month. Or what about our over 140,000 highway accidents in North Carolina each year with a fatality rate of 33.3 per 100,000 as compared to a national average of 25.4 per 100,000?

Time does not permit elaboration of these or other concerns but hopefully we will be able to pursue this topic further in our later discussions.

"Health Planning and Resource Allocation"

George M. Stockbridge,
Central Planning Council
for N.C.

Any time we bring up for discussion the problems associated with our health care system in America we talk about the high, and rising, costs; we talk about difficulty of entry into the system; we talk about fragmented care and lack of continuity; but most of all we talk about doctors.

We note that the generalist of old is being almost totally replaced by the specialist of today. We note that there are usually two ways of being seen by a physician. If it's an emergency, we go to the hospital emergency room. If it's not, we get on somebody's waiting list where we stay for days, or weeks, or months. And we note the odd sort of perversity of the fact that despite all this, we are adding doctors to the population faster than we're adding "people."

We are willing to acknowledge that our most valuable health resource is "doctor time" and know that we should try to build the rest of the health care system around that fact, taking care to eliminate those things which abuse his

time, and to provide those measures which are likely to conserve his time.

The irony of this set of conditions is obvious. And despite the fact that it's obvious, I will proceed to enunciate it. In order to maximize the capacity of the physician and give him the most productive situation possible within which to work, such things as short travel times from home or office to hospitals or clinics, convenient parking, the ability to use the recently created mid-level practitioner (the physician associate and the nurse clinician), sophisticated facilities, and automated equipment must all be considered. Yet these tend to direct the allocation of resources toward a centralized collection point. In short, the necessity to protect the ability of the doctor to see and treat the most patients seems to dictate that we put him where the most patients <u>are</u>. The obvious result of that is to take him away from where the most patients <u>are not</u>: the rural, more sparsely populated regions of the state and nation.

The big hospitals, and a lot of small ones for that matter, are in the cities. The large group medical practices, the specialists and sub-specialists are there also. The alternative modalities of care, such as nursing homes, day-surgery units, home care programs, and primary care centers, these, too, seem to appear more often in the metropolitan setting. Although there is clear justification for assembling these health resources into clusters on grounds of economy, such clustering is frequently not without cost. I went recently to shop for a small economy car. Frankly, I was shocked at the prices, but the salesman said, "If you're going to have economy, you have to pay for it."

There are two particular costs which are most likely to occur in this situation. One of these is the unnecessary duplication of expensive facilities

and services. The other is the leaving of gaps in the fabric of care, with elements of the population left scantily covered or totally uncovered. In short, like so many other segments of our economy, much of our complaint with the health care system may be attributed to problems of distribution.

Public Law 93-641, although by no means limiting its scope to the distribution question, nevertheless appears to contain the best hope of any legislation to date of having a positive influence in this regard. The work to be done under this legislation is to be done by the Health Systems Agencies, the HSA's. And that work may be described just as this little segment of your program is titled: Health Planning and Resource Allocation. These are multi-county organizations consisting of volunteer boards and committees made up of providers, consumers, elected officials, and a small professional staff.

The law calls upon the HSA's for the preparation of two different kinds of health plans -- short range and long range. The long range plan, looking ahead for some five years, is in large measure an expression of health goals for the planning region which may be considered achievable in a five year period. That plan is called the HSP -- The Health Services Plan. The other is known as the AIP, which translates, Annual Implementation Plan. It is at this action level that needs are identified and assessed, that schemes for meeting those needs are devised, and that priorities for meeting those needs are assigned.

There is no doubt about the intent of Congress in the drafting of this law. It is clearly meant to change the way the system functions, to change old patterns, to change the order of importance of many parts of the system. For example, it authorizes $390 million over a three-year period for health facilities construction and modernization. It provides for additional funds

for loans and loan guarantees with interest subsidies. But it sets some clear priorities in the use of these funds. They are: first, projects for medical facilities serving rural areas and those with relatively small financial resources; second, modernization projects in facilities serving densely populated areas; third, outpatient facilities in rural and urban poverty areas; fourth, projects to eliminate or prevent safety hazards, and to assure compliance with licensure and accreditation standards; and fifth, facilities to provide comprehensive care, including outpatient and preventive care, as well as hospitalization. These grants would provide up to 75% of project costs, and even 100% in poverty areas.

As you can see, the direction of that part of the law is away from that of, say, the Hill-Burton Law of a few years back. The clear intent is to limit expansion of horizontal care facilties, concentrating instead on upgrading, where necessary, those in existence, and encouraging the strategic placement of outpatient resources.

The law calls for the establishment of a national council on Health Planning and Development, whose job it will be to develop guidelines for the implementation of a national health policy. The law, again, lists the areas of priority which are to be addressed by this Council. They are ten, and include:

- primary care services for medically underserved populations, especially in rural or economically depressed areas;
- development of multi-institutional systems for coordinating or consolidating institutional health services;
- developing group practices, HMO's, and so on;
- training and increasing the use of physician assistants, especially nurse practitioners;

- developing multi-institutional arrangements for sharing support services;
- promoting activities to achieve improved quality in health services;
- institutional development of the capacity to provide various levels of care on a geographically integrated basis;
- promotion of activities in the area of prevention, nutrition and environment;
- adoption of uniform cost accounting and other improved management procedures among health service institutions;
- education of the public concerning proper personal health care and effective use of available health services.

There are numerous other features of this highly prescriptive law, but I think you must now have a fair idea of its principal thrust. It is a law that tries to limit unnecessary and inappropriate expenditures for health facilities and services. It tries to emphasize the use of less expensive and less complex resources whenever possible. It intends to advise the great American public of ways to protect and improve its health through prudent and judicious life styles. The law wants to see essential services made readily accessible to the entire population, thus providing for their timely use when the need arises.

It is not a wonderworking measure, I would guess. It is <u>not</u> going to make high quality, reasonably priced, readily reached and properly designed health care uniformly available to the citizenry. It <u>is</u> going to interfere at times with the primary desires of individual practitioners and institutions. It <u>does</u> constitute the most serious effort yet to rationalize the health care

delivery system, and it is certain to be applied with an inescapable degree of unevenness, of ineptitude, of naivete. I hope that it will be applied also with a high level of informed participation, with a reasonably solid consensus calling for the sublimation of narrow interests to the larger good, and with a commitment to giving it a fair chance to realize its goals.

It is also the Health System Agencies which will provide the project review service. It is here that proposals come when sponsors wish to build, to expand, to renovate, to furnish, to replace, to equip, to add a new service, to buy, to sell, to lease, in short to change in any important way the capital status quo.

Opportunities abound for each of you to have a part in all of this, and I urge you to take that part. One thing is certain. You <u>are</u> going to be affected by this law. You owe it to yourself to keep up with what goes on in your own local HSA. Everything that agency does has to be done out in the open. There are so many requirements in the law about public exposure I fear we'll get arrested for indecency. We surely won't have any secrets. So go to their meetings. Serve on their boards and committees and task forces when invited. Request and read their plans and reports. Write to them. Talk to them. Get close. With sympathy for the complexities involved, and with supportive, constructive participation by large numbers of people, planning can make you feel better.

"Family and Population Planning"

Thomas J. Vitaglione, Family Planning Branch, DHR

The terms "family planning" and "population planning" are at times used synonymously, and I think this is unfortunate. While definitions are not

standard, family planning generally refers to all decisions which affect individual and familial fertility. (These decisions determine family size and the spacing of children.) Population planning generally refers to decisions which affect community size and demographic characteristics. (Here, community may refer to a neighborhood or the universe.) I am concerned about the synonymous use of these terms because I feel the true goal of family planning is confused and misunderstood when mixed with population planning. Most people think of population planning in terms of volume; and they think of it as population control. When the birth rate declines, I am congratulated for contributing to this goal. While it is true that the size of individual family units is a prime determinant of population size, we in family planning do not have smaller family size as our primary goal. What we are after is the creation of a society which provides its citizens with the knowledge and services to manage fertility so that the potential of the individual and family unit may be maximized. While it is true that most of our efforts encourage smaller family size, it is the health and strength of that family which is of greatest concern to us.

We can think of these families (or units) as building blocks for our community's population. Population planners will be concerned with the number of units and where they should be placed. Family planners will be concerned with the strength of each building block.

Population planning is an easier topic to discuss. It's "safe." Ecologists relate it to quality of life; county commissioners relate it to tax bases; businessmen relate it to future markets for goods and services; and so on. Family planning is not yet "safe" in our polite conversation. It is mystically related to sexuality, and sexuality is still an under-the-table topic in our culture. (By the way, I highly recommend sexuality under

the table; it's great.)

I have interspersed this "cute joke" to reaffirm my point that family planning is not an O.K. subject for conversation. I refer to these jokes as part of the "cute family planning joke" syndrome. For the most part I don't tell people what I do. I have found that most people, in their embarrassment, feel compelled to tell a "cute joke." Moreover, they expect it of me. Even in the Division of Health Services, people will come down to my office to tell a "cute joke" (which would be inappropriate in nutrition, child health, or chronic disease) because they feel the environment is somehow different. I propose that as long as we allow family planning to be "somehow different," our culture will suffer.

For those of you waiting for me to go on about population planning, you might want to take this opportunity to leave. I feel that, given the choice between the two, population planning must receive a much lower priority in our minds. This is so, because population size is simply not a great problem in North Carolina; it is much more important to deal with the strength and stability of the individual family units which comprise our population; and perhaps most importantly, population planning already has an advocacy group in bankers and businessmen. In fact, the only significant appropriation made in this area by our General Assembly, in the last decade, was a population planning bill supported by a veritable "who's who" in North Carolina business.

And so I move on to family planning because family planning is strongly related to the stability and strength of the family unit; and because no advocacy group has yet formed that wields effective power in meeting the family planning needs of our citizens. In fact, that same General Assembly which appropriated funds for population planning rejected a bill for family planning.

In the time remaining (there are so many issues in family planning) I would like to explore two issues: first, our methods for determining family planning needs and why we cannot engender state support of family planning activities; second, our special needs in serving minors and why our approach continues to be so restricted.

The human (individual and familial) needs for family planning are both medical and socioeconomic. We now know that such indicators as the age of the mother, her marital status, her maternal history, and the spacing of her pregnancies are closely associated with pregnancy outcomes. By grouping these variables we can even assign expected risk values for mortality and morbidity. (Recent studies indicate that almost 33% of the recent decline in infant mortality in the United States is due to a higher relative incidence of low-risk pregnancies resulting from family planning decisions.)

In North Carolina our rates of fetal loss and prematurity are high, and while our infant mortality rate is also dropping, we ranked 45th among the states in 1972. This is a shameful indicator that all our citizens do not have ready access to family planning information and services.

The socioeconomic needs for family planning are perhaps more evident and more easily understandable. Most of us here have experienced ambivalently the birth of our own children, for the delight of the "birth miracle" is also mixed with the stress involved with the awesome new responsibility we realize is now upon us. And this is only the case of the wanted and longed for child. It is easy to imagine the overwhelming nature of the stress involved when the birth was not timely -- not wanted -- perhaps despised. There is enough stress on our institution of marriage today, and surely the added problems of untimely and unwanted births exacerbate previously existing problems. It is not surprising that sociologists link our ever-increasing

divorce rates (both in the United States and in North Carolina) with the lack of poor family planning decision-making.

And what about the children in such situations? At a time when psychiatrists, psychologists, and counselors are asserting that most individual psychological and emotional distress is a function of the love (or lack of love) we received in our formative years, it becomes more apparent that our family planning decisions must be made to maximize our capabilities to provide a loving environment for our offspring.

Our current situation, in which divorce is on the increase, and in which fully 15% of our births in 1974 were illegitimate, certainly indicates the need for family planning in North Carolina. Increasing rates of child abuse, and the fact that three-fourths of the children in our Department of Corrections training schools are from broken homes, indicate that needs are immediate and great.

One could go on at great length about the medical and socioeconomic bases for family planning. Let me now move on to outline some of the methods used to determine the volume of service that should probably be provided through our public health sector.

Nationally, family planning afficionadoes have generally adopted a formula developed by Planned Parenthood-World Population which seeks by use of census data and fertility studies to estimate a given locale's need for the provision of public family planning services. The formula estimates the number of women, aged fifteen through forty-four, living in family units earning less than 150% of the federal poverty level, who are fertile and desire not to become pregnant. (The fertility studies provide estimates of those who are infertile, sterilized, not sexually active, pregnant, or seeking pregnancy. These are subtracted from the larger population to

provide estimates of those who would be seeking family planning services in the public sector.) While this formula is based on many debatable assumptions, the estimates provided are nevertheless considered to be some of the most sophisticated available in the planning of health programs.

This formula estimates that roughly 200,000 women will require public family planning services in North Carolina in 1975. We expect to serve a little more than 100,000 this year. Even if we concede that the formula is somewhat faulty, the difference between the estimate of need and the number of persons we serve is perhaps a mindful indicator of one of the reasons for our high infant mortality and illegitimacy rates.

So let us move on to see what the "experts" think is the size of the problem in delivery of family planning services. Two years ago, the Department of Human Resources implemented its Planning-Budgeting System, in which all local health directors (and their constituents) were given the opportunity to define and prioritize their health service delivery needs. Using statistics mentioned earlier, and analyzing demands and resources, 95% of the health directors participating in the System listed their family planning service needs in their top five priorities.

Those of you who are familiar with the 1974 appropriations process already know that the Advisory Budget Commission did not even consider a request by the Department of Human Resources for family planning. The Department had assigned family planning (an obviously important health program with wide professional backing) a budget request priority in the mid-nineties. What happened? Perhaps the Department, realizing that all previous requests of the legislature for family planning service funds had been denied, felt another attempt would end only in frustrating defeat. Perhaps the Department felt that the large federal appropriation for the

program, though declining each year, would be adequate for several more years. While these reasons might certainly be contributory, I would like to propose that we simply do not yet fully understand why we keep failing in this regard, and I would like you to consider some suggestions.

But first let us consider another matter dear to the hearts of all family planning devotees. It is North Carolina's denial of a minor's right to consent for family planning services. I mention this issue not only because of its importance but also because it will lead to my proposed suggestions explaining non-support by state government and the legislature.

Studies in the late 1960's supported by the Department of Health, Education, and Welfare indicated that 37% of unmarried minors (those under 18 years of age) were sexually active. (That estimate is probably conservative today.) Since it is typical of our culture to restrict familial communication concerning sexuality (please think now of all your sexual conversations with your parents; I'm sure five seconds will be long enough), it is ridiculous to expect that minors will request their parents' consent to secure contraception. The result is that 25% of our births in 1973 were to women under 18 (and these are high risks medically); that 64% of our illegitimate births were to teenagers; that over 4,000 abortions were performed on teenagers in North Carolina in 1973. Even assuming that mother and child (or should we say child and child) survive the increased mortality and morbidity risks of this situation, it is evident that birth in these circumstances provides an inappropriate start for a child and in most instances represents deprivation for the mother. This is not the substance with which we strengthen our culture.

We have requested on numerous occasions, legislation which would allow a minor to consent for his or her family planning services. Our most recent

attempt failed in June of this year, when the latest "minors" bill was tabled in the Senate. It was a bill which received only tacit support by the Department of Human Resources and by the Administration. Why? Perhaps, as mentioned before, earlier defeats indicated that lobbying for the latest bill would be a waste of time. This might be part of it, but not all. We are now back to considering reasons.

So here we are in the only state in the southeast which does not appropriate funds for family planning services. And also the only state in this area which denies a minor's right to consent for family planning services. Why? The truth is I simply don't know. I can offer only two suggestions, and I have alluded to these earlier.

The first is the confusion between population and family planning. When our legislators and politicians drive in from the hinterlands and see very few people between home and Raleigh; and when industrialists and farmers alike are concerned over the out-migration of our young people; and when our largest urban center cannot yet support professional basketball and football; and when people think of family planning as population control, it is not hard to understand why family planning might be given a low priority. What we need is more education about the goal and objectives of family planning and the establishment of a "family planning constituency" which will carry our banner.

My second suggestion for the lack of family planning support is probably closer to the heart of the problem and perhaps more unmanageable. It is the sneaky suspicion in people's minds that family planning has something to do with sex. And as we restrict sexual conversation within the family, so we restrict sexual discourse in our media and in our legislative process. Now we could change the name of our service, but I believe Shakespeare would call

that folly. Besides, I think we could call it "Basketball" and still a bunch of people would jump up and cry "Foul." No, we are in a real quandary, for the attitudes that have created the family planning needs I discussed earlier are the very attitudes which are impeding our progress toward solutions.

So where do we go from here? Do we wait a generation for attitudes to change? Is there something we can do to change attitudes quickly? I simply do not know, and beg that any of you interested in this problem join me tomorrow morning for further exploration of this topic. We are the first generation in the entire history of man with the power to control our fertility and thereby enhance our individual and family potential. It would be shameful for our citizens to be denied the opportunity to participate in the exercise of this monumental power.

"Access to Health Care"

William F. Henderson,
Program on Access to Health Care

For the purposes of this paper, we hope it is agreeable to confine our discussion to access as it applies to primary health care.

Most medical care is not rendered for complex and life-threatening illness and involves tasks and services which are simple, non-urgent, well-defined, and inexpensive to provide. While this category of need makes up 90% of all personal health problems, primary care services are the most difficult to find. Only 10% of health needs are complex, urgent, highly judgmental, and difficult to treat. These are the most costly to provide yet are the easiest to obtain. When dollars are allocated, research projects are funded, or facilities are constructed, they most usually are directed at the 10% of the so-called quality end of the spectrum, the implication being that quantity is not important. The following succinct statistics pretty much tell the story in a hurry.

	Metropolitan Counties		Rural Counties			State Average
	Forsyth	Mecklenburg	Hyde	Northhampton	Gates	
Infant Death Rate	18.7	19	59.5	47.1	63.6	22.6
Patient Care Physicians per Population	1:463	1:717	1:5571	1:2667	1:8524	1:982

While we could go on and on in documenting examples of inaccessibility, it would appear to be more productive to spend this time in identifying the major factors that have contributed to the access problem and suggesting some guides for attempting improvements. As we see them, the primary impediments to access have been:

First, the lack of a state-wide and indeed a national commitment to a comprehensive plan for the betterment of health care. Such has not existed in North Carolina since the mid-forties when the Good Health Movement was inaugurated and which later was allowed to decline from lack of public support and enthusiasm.

Second, politically inspired and bureaucratically administered governmental programs, state and national -- many competing with each other -- have lacked coordination with any grand design of priorities. Indeed the "everyman for himself" approach has critically diluted our resources. The medical centers; community providers -- institutions, public and private; mental health programs, private practitioners, to name a few, have had little incentive put before them to pull together a comprehensive mechanism.

Third, the state's general rural nature, its diverse geographical regions and uneven economy inhibit uniform availability of health services.

Fourth, the inattention of both private and public funding organizations to act in concert to establish priorities for health programs has often

fragmented and/or duplicated efforts. As an illustration, while primary or usual illness care makes up 90% of patient needs, only 45% of practicing physicians are in primary care specialties.

Fifth, although ability to pay is an impediment to receiving care, it is not as crucial as knowledge of where to find care. Simplication of the process for finding the portal, particularly by the poor, the stranger, and the ignorant, is vital to substantive solutions.

Sixth, misinformation, as well as no information, about good health care and the prevention of illness is widespread and portends a critical look at prevailing health education curricula in our public schools. We have concluded that massive and intensive education in health for both children and adults is basic to any substantial improvement in the public's health posture.

Seventh, until recently, medical education has not been accountable for producing the number and kinds of physicians that society needs. In 1972 only 27% of residents in training in North Carolina were in the primary care specialties compared to the American Medical Association's recommended goal of 50%. The dilemma of access, however, lies beyond the simple logistics of training more professionals to work the same schedules. The problem is accentuated at night, weekends, and the other times when conventional service facilities are closed.

Now, if we have been applying the lion's share of our resources to the gluttonous end of the spectrum, how do we go about redirecting attention to that end that has been undernourished and perhaps all too frequently starved? It seems to us that in fashioning approaches to correct the imbalance, we need to take the following circumstances into consideration:

In designing programs to bridge the access problem in North Carolina,

our expectations must be tempered by the reality that primary health care is largely delivered in a free enterprise system. Of course, sprinkled in and around this system (or non-system if you will) is a proliferation of uncoordinated health programs sponsored by an array of autonomously administered governmental and private agencies. Understandably, it is difficult to excite these independent and categorically oriented organizations to invest their resources in experiments lying outside their narrow spheres of responsibility. We probably should not expect them to support innovations that threaten their parochial jurisdiction. This orthodoxy, we must appreciate, tends to slow down efforts to generate suitable and willing sponsors of projects that will examine different ways of doing things. Solutions we can deal with must take these constraints into account but, at the same time, attempt gradual modifications that will constructively and persuasively challenge prevailing shortcomings.

In the balance of our time, I would like to share with you the approach the Program on Access to Health Care has taken in shaping projects which we are hopeful will have significant impact upon the access problem.

First, we spent a great deal of time listening to people in underserved areas. We also listened to health care providers in those areas. Combining these conversations with a lot of already documented experiences, it was apparent that huge numbers of people in North Carolina lack the knowledge, convenience, and other means of getting into the access portal. We talked to hosts of people in country stores, on remote country roads, and in rural schools and concluded that our attempts to improve access must take into account the following considerations:

Access to primary health care must be brought very close to the population to be served or else people are not likely to avail themselves of the service.

Simplification of and convenience to the entry portal are especially crucial in reaching the ignorant, the poor, and the stranger.

We should contrive projects generally acceptable to the medical profession and other providers of health services whose participation is vital to the effort's success.

We should try to link our projects to existing viable sponsors that already have identity, clinical and management expertise, and facilities and staff resources, rather than create new administrative mechanisms.

We should avoid the temptation to stress the dramatic and unique and be more concerned with gradualism than crusading. We should stress projects that are geared to the gut issue of getting health services to the masses and attempt projects that lend themselves to promoting systems that have potential for state-wide application. Each potential project should be able to pass the following examination: Does it measurably help mankind? Does it appear practical enough to work? Can we find responsible sponsors to do the job? Does it have potential for continuing support once experimental grants are exhausted?

I hope you will forgive me for relying so extensively upon personal experience but I would like to use the following as an example of how we applied the criteria just mentioned to fashion a project to improve access. When asked, those living in underserved areas pretty much agree that finding services is the most critical aspect of their problem, even more so than ability to pay. The emergency room of the average community hospital is a poignant manifestation of the public's frustration (and we might say, of the private practitioner's as well). It is easy to find, its doors are always open, but it is not usually geared to expediting care for the walk-in sick. Nevertheless, almost two million emergency room visits are recorded annually

in this state. Up to 70%, and in some cases higher, of the visits are of a non-emergent nature and fall within the category of primary care. If we put this in terms of people, it represents 30% of the state's population.

Demands upon emergency rooms are skyrocketing and frustration is mounting over long waits to see physicians on call. This growing trek to the community emergency room cannot be excused on the grounds of convenience only. It is better explained by the fact that large segments of the population, lacking the knowledge or the means of finding other resources, know their way to the local hospital and hope to find there the care they need when they want it.

Hospitals and their medical staffs have made commendable but, too often, futile efforts to accommodate this growing avalanche of patients seeking primary care. They simply have not had the resources to meet public demand and we cannot continue to expect the few physicians, especially those staffing our smaller rural hospitals, to be available 24 hours a day.

Recognizing that more and more people are turning to the hospital emergency room for primary care, the Program on Access to Health Care proposed grants to hospitals to assist them and their medical staffs in retaining the services of full-time physicians in their emergency rooms. With assistance from the Duke Endowment, the Kate B. Reynolds Health Care Trust, and the Z. Smith Reynolds Foundation, which support the Program on Access to Health Care, some 20 hospitals have retained a total of 30 physicians during the past 12 months or so. We are watching this experiment to assess its capability of increasing the quality of care in the hospital emergency room and in expanding the hospital's capability of serving more people.

Very quickly, the results of this experiment have been gratifying. Patient visits are increasing -- some as much as 60%. Larger numbers of Medicare and Medicaid recipients are being treated -- one hospital reported an increase of 360%. Another predicts that its ER visits will double in six months. Still another hospital in eastern Carolina reports that 65% of the patients seen are blacks. The public and the hospitals and medical staffs are unanimous in their praise of this approach in extending access to large numbers of underserved people. It is estimated that these twenty hospitals will attend between 300,000 and 400,000 people in their ER's during the first year of the program's operation.

The state's plan of establishing primary health care centers in rural communities manned by family nurse practitioners and physician assistants is another example of simplicity in contriving access portals.

Let's not look for glamorous solutions or idealistic ones. Rather, let's seize upon, if we can, existing responsible and familiar mechanisms and tempt them to diversify and expand their efforts. Again, we think it is important enough to bear repeating -- primary health care must be developed close to the people and simplification and convenience are crucial factors if the entry point is to significantly benefit the underserved -- especially the poor, the uninformed, and the stranger.

"Consumer Education in Health Care"

Lillian Woo, Consumer Center for N.C.

Like food, shelter, and clothing, health care is a necessity for all people. But soaring costs, coupled with fragmentary services and shortages of health care providers have made it financially impossible for many patients to afford minimum health care maintenance and periodic examinations.

The health care industry in the United States is a staggeringly large

one. It grosses about $80 billion a year at present and increasing costs will see the total figure continue to climb.

Between 1959 and 1972 medical costs rose 95% and hospital charges increased 200%, and there is no end in sight. When these figures are compared with the rate of inflation of less than 50% during that time, it is obvious that medical fees and charges have increased more than the cost of living index and more than humanitarian dedication should have allowed.

Quality care is costly. Medicine seems to have become an assembly line profession and health insurance covers sickness rather than well visits to the doctor.

In the midst of these dismal circumstances, our greatest health resource of all turns out to be health education. Attitudes and perspectives of health instruction have changed enormously in recent times. Health education used to take a negative approach -- don't do this and don't do that. Today we stress the positive -- what to do to maintain and promote health.

We have evolved from the days of the horse and buggy doctor and simple living to the days of high powered specialists and a complex urban society. To those of us who are neither health care providers nor health educators, the needs of today dictate a look at education and total human health. The view of curative medicine and immunization is no longer sufficient.

It is necessary to educate the lay public about individual physical health maintenance, individual mental and emotional health, adjustments to rapid changes in life style and mobility, and the community environment which can affect the health of everyone who lives within its boundaries.

It is no longer sufficient to prescribe a timetable of immunizations and a balanced diet. It is time to look at the wonder cures and procedures of modern medicine in the light of an ever-changing social pattern, the

insecurity created by big business, big government, and their attendant economic problems.

If we could merely live our lives in the tranquility and stability of Walden's Pond, we would only have to cope with the simple task of fighting infectious and communicable diseases. Although it is no small accomplishment to successfully stamp out malaria, typhoid fever, and small pox, the challenges which confront you today are far harder to meet.

Let me outline what I feel the important role of health education is.

First, in terms of individual health maintenance, it is vital to educate citizens about the necessity of periodic check-ups and preventive care. Here in North Carolina where there are wide gaps in medical availability in the rural areas of the state, the role of the health educator is crucial. Health educators must extensively inform the public about the need for regular check-ups, x-rays, pap smears, inoculations, and dental care. Health educators must also work to insure that health care providers and medical teams are attracted to rural areas in this state, and work to establish clinics, health centers, and mobile units. Working with both the public and the medical profession, health educators can help maximize the number of patients seen by doctors through an educational program that allows patients to give their health profiles to paramedics and nurses; allows them to fill in forms before arrival, thus saving staff time; and allows them to deal with the physician honestly. A third area in preventive care where health educators can serve an invaluable function is to work toward broadening the coverage of health insurance. At present, only 22% of total health care costs are covered by insurance and most of that is for illness. Very little coverage is provided for preventative care and health maintenance. The insurance companies should be persuaded to cover this

vital area of health. After all, an ounce of prevention is worth a pound of cure. And besides, it's cheaper and less painful.

Second, in terms of clean living, proper diet and a balanced physical regimen, the health educator's role becomes progressively more difficult but more challenging too.

Common sense tells us that we need an adequate and balanced diet, good nutrition, and certain minimum daily requirements to keep fit and healthy. Yet, that is not as easily achieved as we wish. The food industry, which started out to preserve foods by pickling, salting, drying, and canning has expanded beyond even their own visions and imagination. The American public is the hapless victim of innumerable additives which make food more colorful, less cloudy, thicker, smoother, more cohesive; in short, additives that make food appear artificially what it is not.

We claim to be fully aware of the drug culture in which we live. Kids dose themselves with LDS, marijuana, heroin; adults wolf down tranquilizers, amphetamines, barbituates. But few people ever seem to care that we are a nation of food junkies.

People who are dying have a choice about whether they want an experimental drug that may kill or cure them. The doctor explains the risks and the patient can take it or leave it. The decision is called "informed consent" in medical terminology.

But the American people, who are so dependent on the vast network of mass-produced, processed food, cannot take it or leave it. We don't have the right of "informed consent."

We have placed our health, safety, and trust erroneously in the hands of the Food and Drug Administration, and it is imperative that the public is informed about the dangers present in certain additives.

Health educators can fill this important educational void by disseminating information about additives and their potential harm and by persuading the FDA to fulfill its responsibility to safeguard the health of the American people.

No matter how balanced a diet may appear to be, if the foods ingested contain carcinogenic and other harmful additives, you're sunk.

Third, the high mobility and fast pace of life have created an uncertainty in many citizens about their values, about their goals, about their self-worth. The constant social movement coupled with a society and government which have grown to sizes which boggle the mind and frustrate any brave soul, have created a brand of citizen riddled with subconscious stress and internal turmoil.

Health educators and all health providers must now add emotional health to their already heavy load of responsibilities. Teaching citizens to acknowledge stress as a first step to coping with their anxieties is a new area which will become increasingly important.

We are always dismayed by outbreaks of violence, assassinations of our public figures, attempts to take the President's life. But if we stop to analyze the cause of the intense hostility and aggressions which have built up inside too many young people today, we will discover that our society has fallen short in providing security, stability, and a sense of self-worth in our citizens. We have also failed to educate Americans about emotional health and how to cope and deal with stress.

As we see violence, as we see increased addictions to drugs and alcohol, as we see greater numbers of smokers, as we see one fad after another promising tranquility, we cannot help but conclude that we are a nation desperately in need of an educational program to improve our mental and

emotional health, to increase our sense of self-appreciation and pride.

We cannot preoccupy ourselves and devote all our time and money to find a cure for cancer or a miraculous new organ transplant, when people are rotting emotionally in record numbers.

Individual health is a totality -- physical, mental, emotional. Educators must expand their scope to insure that future generations will have proper protection and conservation of good health in all these areas.

Fourth, in the area of public domain, concern about the quality of water, air, pesticides, waste disposal, and radioactivity surpasses the ken and money of the individual. These broad public interest issues must be taught to our citizens so that they will become knowledgeable on these subjects and will be concerned enough to work on their behalf in their communities and states. A social awareness about these issues is important to insure protection and public health in the future.

According to the March of Dimes Foundation, 80% of the birth defects are caused by food additives, environmental pollution, befouled water and air, drugs, and smoking.

The American public needs your training and efforts to help citizens achieve individual and community health. Judging from the expansiveness of the areas I've covered, it is no small task you face. Nor is it an easy one, but certainly it is inspiring and challenging. For if each one of you can play some part in its total achievement, we and our children will be forever grateful.

"Occupational Safety and Health"

John C. Lumsden,
Occupational Health Branch, DHR

It's a pleasure for me to be with you today and encouraging to have

Occupational Safety and Health an area of concern at this convocation. Many work environments, particularly in the manufacturing world, present to employees both injury and health hazards that claim an inordinate number of lives each year and produce many serious disabilities. Aside from the human suffering that results, the monetary losses borne by the public are staggering.

The control of these preventable tragedies are the concern of those of us in the occupational safety and health field.

Industrial safety involves complicated technology for the prevention of catastrophies from mechanical, electrical, and chemical causes, and the concept of the trauma produced by such occurrences is clearly before us. Industrial health problems, however, may not be so clearly seen or understood. A few examples of the typical industrial health problems I am referring to are:

Workers being exposed to airborne mineral dusts such as we find in mining and quarrying operations, stone cutting and foundries. These dusts contain silica and cause silicosis, an irreversible and disabling lung disease.

Insulation workers, asbestos textile workers, and friction material workers inhaling asbestos fibers. This causes asbestosis, another irreversible fibrotic lung disease and, in recent years, asbestos has also been considered carcinogenic.

Workers being exposed to excessive noise levels. This results in serious loss of hearing acuity.

Workers being exposed to toxic vapors and gases or fumes from metals entering the body through the lungs. These attack specific organs or systems in a host of insidious ways to produce dysfunction and disability.

Workers enduring heat stress in hot industrial environments.

Workers developing severe dermatitis caused by contact with solvents and vapors.

Workers exposed to ultra-violet radiation from welding or special lighting which can damage eyes and skin. There are also the effects of ionizing radiation from industrial x-ray or radioisotope use.

Workers facing biological hazards from organisms that may be peculiar to the raw materials used in a particular manufacturing process.

There are thousands of such possibilities in today's industry. In fact, the most recent listing of toxic industrial chemicals alone contains information on over 20,000 materials.

In North Carolina, as in most other states and the federal government, health and safety are treated as separate programs that require different approaches as far as control programs are concerned. Even though both have the common goal of protecting the health, well-being, and productivity of the same target population, there have existed separate efforts by different agencies in these two areas.

The major activity for many years of the North Carolina Department of Labor has been in the field of industrial safety while the Division of Health Services has had the program for industrial hygiene or health. There has been and will be close coordination of activities between these two agencies, however.

The separation of these programs resulted simply from the difference in the nature of the beasts. Industrial accidents are observable events that are dramatic and impressive. The cause and effect of the accident is usually clearly discernable and the control measures needed to prevent a reoccurrence are apparent. Safety programs, then, have these recorded events to produce impressive statistics and have enjoyed visibility both in the

eyes of the general public and the industrial sector.

Occupational diseases, on the other hand, usually develop over relatively long periods of time from chronic exposures to hazardous chemical materials or physical agents without any dramatic onset. Consequently, the necessity for the control of these chronic exposures frequently has not been recognized by industrial management, the potentially affected employee, or even by his attending physician.

All too often, in the past at least, occupational illnesses have not been recognized as such and when they were recognized, were not reportable, so that significant problem areas were hidden from the view of epidemiologists. Industrial management was not required and could not be expected to report patterns of illness observed among employees.

For example: respiratory disease among textile workers is not a recent observation, having been recognized and described first by Ramazzini in 1713. Since that time, there have been numerous medical accounts of byssinosis among hemp, flax and cotton workers. Over 500 references to this occupational disease and related subjects can be found in the world's literature. Even with this apparent degree of recognition, byssinosis remained for many years an obscure condition about which little was known. Indeed, even today we are not too much further advanced in our knowledge. A survey made by the United States Public Health Service in 1933 concluded that there was no particular respiratory affliction among American cotton textile workers. North Carolina studies made in the last few years appear to refute this earlier report and indicate that the textile industry is, in fact, faced with a problem of considerable but not insurmountable proportions.

So we see that occupational health programs have not had the advantage

of hard data and statistics to promote their activities or to make reasonable evaluations of previous efforts.

It appears now, however, that occupational health programs may have passed through the "Dark Ages" and are beginning to emerge into the light of public and governmental attention. The present day recognition of the federal government is evidenced by several pieces of legislation such as the Walsh-Healey Act, setting health and safety standards for government contractors; two mine safety acts, setting workplace standards for this particular industry with its unusual and serious problems; and most recently, the Occupational Safety and Health Act of 1970. This piece of landmark legislation establishes health and safety standards for virtually all industries and occupations where there exists an employer-employee relationship.

In 1973, North Carolina assumed the responsibility for administering the Occupational Safety and Health Act, by agreement between the Governor and the Secretary of Labor, and continues at this time under the close scrutiny of federal officials.

As mentioned earlier, responsibilities for the OSHA program are shared by the Department of Labor and the Division of Health Services with the Department of Labor as the administering and enforcing agency. Some 3500 safety inspections and 400 to 500 health investigations are now made annually.

So we see that occupational health <u>care</u> cannot be delivered by a government or altruistic agency in the manner that we can deliver immunizations, prenatal care, rehabilitation, or the many other health services. Occupational health care is essentially in the hands of management and labor. Employers must provide safe working environments with effective

hazard controls and the employees must take advantage of them through proper use.

The government's role then becomes advisory to these two groups, encouraging voluntary compliance with accepted standards, but retaining policing authority when needed.

THE OPEN FORUM

“ . . . equal time for both consumers and providers . . .”

GROUP REPORTS

During this portion of the Convocation participants selected one of eight different groups organized to discuss topics covered in the presentations of the previous day. These sessions were informal and free-flowing, with group leaders posing questions and raising issues of particular importance. Comments were made, opinions expressed, and sometimes, consesus reached, but essentially they were in the nature of dialogue among professionals rather than structured interactions for the purpose of reaching definitive conclusions.

In the Open Forum which followed, group leaders were called upon to summarize the directions of these discussions and to share their major points. Dr. Cecil Sheps presided, dividing the eight groups into two categories. Those dealing with "end results" or basic health objectives -- Occupational Health and Safety; Access to Health Care; Quality of Health Care -- and those dealing with subjects essential to the achievement of those results or basic health objectives -- Health Manpower; Economics of Health Care; Health Legislation; Health Planning/Resource Allocation; and Consumer Education.

"Occupational Safety and Health"

Carl M. Shy, M.D., Environmental Studies Institute, UNC-CH

I can summarize in one sentence the direction of our discussion on occupational health issues. It was the recognition that there's a major trend in providing services for occupational health. And this trend will bring about some very important changes for both stimulating industry to recognize the need for occupational health services and then mobilizing at the local health department level to provide these services. This is a great change of activities for the occupational health, public health sector in the state of North Carolina.

We first of all noted that occupational health problems are widespread in North Carolina. One of the major problems is the lack of data on the prevalence of occupational diseases and disabilities and on hazardous exposures. At the present time, there is no systematic surveillance of occupational disease problems in North Carolina and therefore no reporting of occupational health problems to any central agency. We do have some surveillance going on now with respect to silicosis, primarily in the brick industry where exposures to silica in the manufactured bricks occur; surveillance with respect to asbestosis; and surveillance with respect to visimosis, or the brown lung textile cotton dust problem. However, even in these areas, the surveillance is being undertaken only in the major industries or the larger firms. The widespread smaller plants have virtually little in the way of occupational surveillance for these problems.

We asked ourselves: What is the incentive for increasing the collection of data and therefore recognizing the magnitude of the occupational health

problem? One of the incentives could be the insurance carriers themselves. Unfortunately, they don't have the incentive because there are not a large number of claims coming in to them through the industrial commission. For instance, right now there are 75,000 cotton workers in North Carolina. Surveys of byssinosis indicate there might be at least 2,000 to 3,000 workers with active byssinosis in the industry who ought to be compensated or somehow be eligible for disability payments. And yet in the last five years, we've only had 63 applications to the industrial commission for disability for byssinosis.

In North Carolina the cotton dust exposure problem is controlled by a work room standard for exposure. Monitoring of this standard is performed by inspections, usually initiated by the OSHA, or Occupational Safety and Health Administration, of North Carolina. Altogether, there are about 35 inspectors who have to cover 100 counties. And as you know, the textile industry is widely dispersed throughout the state and it's virtually impossible for them to follow even one industry for compliance. When an industry or individual plant is not in compliance, then an abatement target is established by the Department of Labor. The abatement program itself, as established by the Department of Labor, may be reacted to by industry, but there is no other group that oversees the feasibility or advisability of this target schedule. There is no public interest group that represents the worker or the public at large to give some stimulus, either to the Department of Labor or to industry, to be in compliance with the health standards.

We recognize noise as a widespread problem in North Carolina because of the textile industry, cigarette manufacturing, and the quarry and construction industry. In contrast to respiratory disease problems, there is a short term

preventive measure that is effective and is largely being used -- ear plugs. Also, we have concern with the furniture industry, which has a large variety of solvents and lacquers that may represent health hazards, as well as with tobacco growing and other farming using pesticides.

With all of these problems, we felt the local health departments could take a major role. First of all, their own sanitarians could expand their services by developing greater competence to inspect industry and recognize hazardous occupational exposures. This will require more industrial hygenists trained at a four year level. But there's also a possibility for two-year associate degree persons trained at our community colleges in occupational health and safety. In fact, there are now five community colleges in the state that offer these associate degrees. We feel this pool should be considerably enlarged by expanding the training at community colleges in occupational health and safety.

We also felt that the health departments themselves have difficulty providing incentives to industry to request services for medical and environmental surveillance. They need help either at the state level or from the public interest sector. We identified, for instance, the North Carolina Lung Association as a group which could assist them by helping industry to recognize their problems and by stimulating the Industrial Commission itself, which has a significant access to industry throughout North Carolina. The Industrial Commission, which is a separate entity from the Department of Labor, operates through eight regional councils which have 600 corporate members with about 90,000 individuals. They have regional meetings with 300 to 600 persons attending. One of their functions is to educate industry but their focus has been on accident prevention. We feel that the health

sector in North Carolina could help the Industrial Commission in focusing on occupational health problems as well.

So that is the challenge: additional training of sanitarians; greater emphasis on industrial surveillance; more medical surveillance; and public interest groups assisting in coordinating the efforts of industry with local health departments to provide occupational health services.

"Access to Health Care"

Donald M. Hayes, Department of Community Medicine, Bowman-Gray School of Medicine

I appreciate this opportunity to tell you about the deliberations of our group and to congratulate all of the people who helped to reach some of these conclusions. We divided our time between identifying some of the problems related to accessibility of health care and then giving consideration to possible solutions to these problems. There are certain basic assumptions which we were all willing to accept but which are not matters of fact. Two of these were specified. First, increased accessibility of health care results in an improvement in the health status of the population. This is an assumption carried by health professionals but not one which is proven in fact. Second, the public is indeed interested in having access to what health professionals think they should have. That also is an assumption that is frequently made that is not necessarily founded in fact.

Proceeding on those assumptions, problems in North Carolina were identified. One problem involves a large group of people with a variety of chronic diseases. Many do not have available to them adequate continuing care for their particular situation. They cannot go to acute care centers such as the emergency room for obstructive pulmonary disease, arthritics and

a variety of other chronic illnesses. Another problem is that of the geography of North Carolina, both in the fact that it is a largely rural state and that the transportation system in certain areas leaves much to be desired. A third problem identified was that of the complexity of the existing system as perceived by the consumers of care. In subsequent discussion it was pointed out that this perception is quite accurate. Our system is unnecessarily complex and cumbersome and sometimes actually constitutes a barrier itself to accessibility of care. Another problem is a concept of territoriality held by some existing health professionals. Often we ourselves are a barrier to access because of our attitudes and practices.

We identified the problem of need for improving pathways within the system, of referral, of expeditious management of patients with a variety of diseases who need input from different types of health professionals. There is also a need for health education within the public in general, for people to know how to care for themselves better, for people to know how to get into the system, and how to maneuver about within that system once they have done so.

We also identified solutions to some of these problems but ended up with two pages of problems and one page of solutions. That probably tells you something about where we stand. Solutions to the problems can be classified under two large headings: Solutions which could be carried out within the existing system, and solutions which can be called non-traditional, using modes which are not generally accepted as part of the system.

Among the solutions which were suggested was the extended use of the state's existing crisis intervention centers. Many of these were started to deal with mental health crises or drug abuse. Because of demand or need

they have evolved to a point where they are now helping people with life crises and are viewed as primary care facilities by large segments of our population. There is a need for more utilization of physician extenders as they are now used in some of the rural, primary care clinics around the state. Some of the programs using a combination of first contact and emergency care being undertaken by smaller community hospitals should be expanded. There is a need also for more effective incorporation of mid-level practitioners, such as nurse practitioners and physician assistants, into the existing system. We spoke to the wedding of Area Health Education Centers and community colleges in reference to the need for public education. AHEC at this point is devoting itself predominantly to professional education, but their mission should include that of public education as well. The community colleges may constitute a vehicle through which this could be brought about. The removal of financial barriers was spoken to briefly. National health insurance has been "just around the corner" for about ten years now and many of us are probably using that as an excuse not to address the problem that certainly exists in North Carolina.

Finally, there is a need for a coordination of present facilities and services within North Carolina and for the wider use of existing health professionals. Two large pools of health manpower were mentioned: Health departments and pharmacists. Chiropractic physicians may represent yet another pool of untapped health care professionals who can contribute to making the system more accessible. But, whatever system is evolved by a particular community, it is clear that it must have adequate management, not just from the standpoint of medicine or health care. It will require management as far as people and business and fiscal interest are concerned in order to assure that it will succeed. High ideals alone are not enough.

"Quality of Health Care"

William C. Parker, Jr., Piedmont Medical Foundation

Although these people at the podium would probably disagree with me, I think that our group had perhaps the most elusive concept of all to deal with this morning. I want to commend them for doing such a good job. Let me give you some of their impressions about "Quality." First of all, quality is defined in the eye of the beholder. Even with that in mind, often it is defined without any real concern for what the patient perceives as quality. We tend to define it as we providers see it. One point that's already been mentioned is the recognition that territorial imperatives often serve as a great deterrent to quality in many of our communities. Quality also is directly related to the "state of the art." But the question came up -- can we really set a floor on the quality of that "state of the art?" When economics become involved, do we know what the payoffs are for trying to set some minimum standards of quality? And that is, of course, compounded by the fact that nobody in the group could come up with a single definition of quality. Everyone brought in a different idea. It's hard to separate the quality of life and the quality of health care delivery. Because of this, we ended up with a fairly broad approach, which I think you'll see in our recommendations. Finally, quality of care is often directly proportional to the dollars available. And that's a quantity problem, which was addressed in nearly every speech yesterday.

Our discussion began with very general aspects of quality, talking about the problems in assessing the needs and in coordinating a non-system of providers. With a lack in the "state of the art" of quality assessment, it's hard to document whether we have good quality or not. A hospital or a health

care facility has to provide assurance of quality in all kinds of different areas but nobody has come up with a good set of criteria with which we can assess quality care in such institutions.

We touched on other aspects including access, the economics, and acceptability of care as an aspect of quality. One broad deficiency that our group recognized was the lack of quality in preventive medicine and health education. My group implored me to get the ear of the legislators in this regard. It was felt that if a course in "capitalism" (free enterprise) could be mandated by the legislature, then possibly, a mandated look at health education in our school system might also be in order. Whatever we do, it will be important to present the material so that it is attractive and interesting to those who are receiving the instruction.

We went on to discuss the Peer Review Program that the state and private corporations have put together. The group felt that this was certainly a step in the right direction although, at the present time, the physician and not the patient is the focus. We also looked at the public health sector which has a good deal of impact on the quality of life and the quality of health care for many of the citizens of North Carolina. The county health departments will have minimum standards going into effect in July of 1976. The observation was made that 85% of county public health money comes from the counties, increasing the possibility of fragmenting of services as well as the territorial imperatives that we mentioned earlier. More state control and state funding might alleviate this problem.

There was some discussion regarding social services such as the emergency medical program that the governor talked about yesterday. We looked at the quality aspects of what the state had been doing, and the general consensus was that the programs that were mentioned were admirable. They had

been set up in such a way that quality was promoted, they impacted on access, and were beneficial. The emergency medical system was pointed out as an example of adequate funding and good planning, bringing us from a marginal level to a fairly respectable level in the state. In the final analysis, we felt "Quality of Care" relates a great deal to economics and to the establishment of priorities. And in hearing the discussions yesterday, the priorities appear to be in the quantity aspects of health care. I would hope that as we solve some of the quantity problems that priorities will be closely reassessed and that soon, more of the Gross National Product will go into quality improvement measures.

"Health Manpower"

James C. Leist, Northwest Area Health Education Center, Bowman-Gray School of Medicine

As our group approached the problem of health manpower this morning we were overwhelmed because of the magnitude of the issues implied by the term health manpower. Thus we focused on four issues: the shortage, the distribution, the utilization, and the education and training of health manpower.

Our primary discussion centered on the utilization of existing manpower. There was some feeling expressed in our group that we must better utilize our existing health personnel in North Carolina. There was a feeling in our group that there needs to be a better understanding of the role of the physician extender or mid-level practitioner in North Carolina. We are probably a leading state when it comes to accepting and using these kinds of people, but a broader acceptance of their role is required if they are to be utilized most effectively in primary health care. Also there needs to be improved utilization of other kinds of health personnel. Expanded roles for nurses are being considered.

There was some feeling in the group that chiropractors could provide some primary care, also.

We touched on a recurring theme echoed in many of the previous reports - that individuals need to be better educated about health matters. We support the concept that everybody in the state is part of the health manpower team and should play a role in taking some responsibility for their own health.

In addition to the utilization issue of health manpower, we talked about distribution or maldistribution, if you will, in the state of North Carolina. This is obviously a problem when you deal with health manpower. We pointed out two things that have an impact on distribution that perhaps need to be addressed. One is the hold that accrediting bodies have on the kinds of education and training programs that can be conducted here. For example, accrediting bodies suggest that training can occur in certain places and cannot occur in others. If we're going to deal with training people in a rural area, we need to make use of educational facilities, clinical facilities, and teaching manpower in those areas. Accrediting standards sometimes do not allow for that. So this is a limitation which has some impact on distribution, although AHEC is addressing that problem to some degree. It is still a hurdle that we need to overcome. There was one other concern that had to do with the selection procedures used by educational institution. If we follow past selection procedures, we're going to admit a certain kind of student in our educational institutions which may not help us resolve the primary care shortage of health manpower or the distribution problem.

Finally, we spent a few exciting minutes talking about education and training. Obviously, there was a lot of interest in this area. We discussed the need for lifelong education as a way of learning the necessary facts relating to a job. But the dialogue pointed out that the most important need

is to develop appropriate attitudes for the humanistic kind of approach that all health personnel must bring to their job as a provider of service.

"Economics of Health Care"

Robert Diseker, Department of Community Medicine, Bowman-Gray School of Medicine

I'd like you to join with me for a moment as though reconstructing the creation, sitting here in darkness, which makes us uncomfortable, and in silence, which also makes us uncomfortable, in the void, if you will. And all of a sudden there is light, for God had created light. And not to be outdone, a moment later the lights go out and there is darkness, for the devil had created darkness. And then, after thinking about it, God created good. And a moment later, we had evil. And there begins the juxtaposition of forces: good and evil; light and dark. The next move on God's part was to create an economist, which was immediately followed a second later by another economist whom the devil had created. This should give you a feel for the notion that where there are economists, there are countervailing points of view.

Our group today, though we didn't have economists with us, perhaps fortunately, was also partial to countervailing points of view. But I think we had a very interesting process that I'd like to share with you. We began to explore the values that are involved in the whole health system by going through a little exercise to allocate, as a closed society of ten people, a thousand gallons of gasoline. Through that process, we became aware of the values underlying the allocation -- the value of equality, the value of need. Then we got into the free market where one individual could garner the market and, in a sense, could control this scarce resource. Through this exercise we began to understand some of the values that are at play in the health system today. And those values impinge upon the decisions that we make in

the market and in the allocation of economic resources.

We talked a little about hospitals as a component of the health system. Hospitals account for roughly 40% of the health care dollars that are being used and, in some cases, misused in the sense that those dollars are not available to be spent elsewhere for other kinds of services. We talked about extenders. We talked about different categories of health professionals as a possible way of finding innovative solutions to the health care crisis that affects each of our pocketbooks. We talked too, about the roles that we individually and collectively play in the economics of the health system today and have some recommendations to make. These are in two areas. The first concerns cost containment. The second concerns the communication of innovations throughout the system.

In the area of cost containment, we thought that the North Carolina Health Council should take a position on the promotion of cost containment while maintaining quality. This position should be directed at all levels of the health system including government, the health insurers, and the provider groups. (I might add that I am not speaking from any consensus but just reporting these different proposals.) We felt that an important cost containment measure would be just to acquaint providers with the cost of services. There have been studies that have shown that physicians who are made aware of what laboratory procedures are costing are going to be less likely to overutilize those procedures. Another recommendation concerned the North Carolina Health Council and utilization review in the hospitals; utilization review for pharmacists; and for all categories of health providers in today's health system. A final recommendation in this area concerned payment for services. Perhaps the insurers and third party payers could be encouraged by organizations such as the North Carolina Health Council, to pay for services

rendered in innovative settings by different types of health professionals, including preventive services.

Concerning the second category of recommendations, the communication of innovations, we believe that the North Carolina Health Council should examine statements by other organizations such as that by the American Public Health Association's recent task force on prevention. Guidelines could be developed incorporating prevention as a topic that could be addressed through public education in North Carolina, through the media, and in other ways. We felt that the Council has a role in the dissemination of information about innovations in today's health system. It is a neutral forum where ideas can be shared concerning innovative cost containment mechanisms occurring in hospitals, innovative programs utilizing different types of health professionals, innovative consumer and provider educational programs. We felt that the promotion of patient care training is important. For example, self care for patients with hypertension could reduce demand for costly time of health professionals by having people in the family learning to take blood pressures. We think the Council should take a stand on patient education to strongly encourage and promote it throughout different provider groups so that more providers will take part in the delivery of such education to patients. Finally, we feel that the Council should bring together all interested parties to discuss what is happening in the Health Systems Agency movement across the state. We believe that this is a movement that portends significant change in the health sytem and that the Council can play an important and influential role.

"Health Legislation"

Thomas W. Ross, Institute of Government, UNC-CH

We had a very diversified group including two members of the state legislature. We had people from the academic world. And we had health professionals of all types -- nurses, administrators, planners. We covered many areas. I can summarize those quickly by saying that we talked about almost everything that every other group talked about. But we tried to look at things from the point of view of the types of legislation that would be needed in order to find solutions to our problems.

The executive director of Wake Health Services gave a presentation on prepaid group practice, Health Maintenance Organizations. Right now HMO's are not legal in this state but he made a strong point that they ought to be. We talked about the need for improving eugenic sterilization law in North Carolina. We talked about the need to clarify and improve the ability of minors to obtain health services without parental consent. And, although it doesn't call for state legislation, we discussed the problem of nonconformity at both the state and the local levels with respect to health services offered to Medicaid recipients. We also examined the problems of the professional licensing boards; how they interrelate and work with each other. I think we reached some consensus that perhaps this area needs a comprehensive study, with input from all health professionals. A recommendation was made for malpractice arbitration in North Carolina as well.

Perhaps the major concern was that most of the health legislation in North Carolina has been enacted in a piecemeal way. The legislature has responded to particular issues or particular crises rather than looking at the comprehensive health law needs in the state. One of our representatives

reacted to that criticism by saying that the probable reason for that is the fact there are so many diverse groups of health professionals and consumers. Consequently, requests for legislation have been piecemenal also. A recommendation was made to get at this problem -- to undertake a comprehensive study and a comprehensive revision of North Carolina's health laws. That's a big task and to do it right we would need to have participation from many sources. Michigan is trying to do this, having hearings with health professionals from various areas, lawyers, and other people concerned about health. In this way they hope to draft a comprehensive legislative plan. We also mentioned a few topics that have been discussed by other groups. Health education legislation was one. We, too, see the need to have a continuing health curriculum in the public school system.

Finally, a point was made that I think we all need to keep in mind -- when laws are passed, those who are responsible need to hear from the people who have to live under those laws. They need to know how well they work or if there are problems in their daily operation. But even more important, before such laws are passed, health workers must learn how to lobby more effectively. The lack of a common presentation of health care problems remain a serious impediment to comprehensive health laws.

"Health Planning and Resource Allocation"

Larry Burwell, State Health Planning and Development Agency

Congress passed a piece of legislation several years ago, the Comprehensive Health Planning Act, which gave us the responsibility of planning a rational health care system. But beyond that, it didn't say much about what it was going to do or how it was going to do it. We now have a new piece of health planning and resource development legislation simply called that, the Health Planning and Resource Development Act of 1974. It doesn't speak about

these responsibilities in a comprehensive manner, but it does define ten priorities for health planning that should be considered as planning agencies get under way. It just so happens that these ten priorities deal with most of the subjects that we've discussed here today.

We looked at the health system, as health planners are prone to do, in reference to a model that speaks to needs on one hand, demands on another; to services on one end and resources or supplies on the other. We talked about how health legislation in the past has impacted in one of these areas. For instance, health legislation that dealt with the development of health facilities across the country resulted in an over-supply of health facility resources. The assumption was that if you develop resources, the services will follow to meet an undefined health care need. Now we have an oversupply of health care resources with an under-utilization of health services in certain areas. In the same way, we have health manpower as a resource that has been generated by various pieces of health care legislation. But the resource is unevenly distributed and unevenly planned for. One really has doubt about how well it is utilized. Money resources create a demand on services which in turn demand more resources. The relationship between meeting needs and the resources available to meet those needs has not been adequately examined. However, this new piece of planning legislation makes the assumption that this will be done. Agencies are supposed to develop a health plan, whether it's a health service plan or a facility plan or a manpower plan. Somehow or other, they are to allocate the resources against the plan, making priority decisions about what levels of needs will be met. Are we going to be able to meet 100% of the expressed and defined need, or are we just going to meet 60 or 70%? That's going to be the real test as to whether health planning and resource allocation works. As we discussed all of these issues, the

consensus was that health planning needs to take into consideration several points of emphasis.

The first of these points is that past health planning has concentrated on the development of facility resources -- hospitals and most recently, nursing home resources. The feeling was that the emphasis on resources needs to be changed from an inpatient to an outpatient stance -- to the ambulatory, rural health care, home health approaches that are already in existence. The second point is to consolidate health facility resources and health services resources on some kind of integrated basis. The task there is going to be: Who's going to manage this integration? Will public and private health resources be integrated? And if so, who's going to "call the shots" on that integration? And this, too, will be a real test because each has domains to protect and each has economies to protect. The third point is to define standards around which needs are going to be met. Right now needs are defined on anything from Ouija boards to computer simulation models (or, on the basis of whoever hollers the loudest). A well thought-out definition and methodology of needs against standards is necessary to a successful health planning effort. Another point that was discussed concerns the need to develop an educational strategy for the consumer, the provider, and the elected official at the local, state, or national level on the utilization of facilities and services. That generally takes in the universe of those who will be affected by this piece of legislation. And the final point, health systems agencies, in their deliberations of these very broad issues and in their movement toward the resolution of them, must develop broad public awareness approaches to inform the public to invite them into these councils and to seek their participation.

The legislation has categorized ten priorities for consideration. They

speak to the development of primary services, multi-institutional services, Health Maintenance Organization group practices, arrangement in the sharing of services, promotion activities in prevention, nutrition, environment, the adoption of uniform cost accounting methods, and education of the public concerning proper use of services -- some of the very points we have discussed. The question is: can the law address itself to these concerns and to the health care problems we now have? The consensus of the group was that we have yet to see what the legislation will accomplish, but it does indeed have the potential.

"Consumer Education in Health Care"

Joann Flair, Patient Education Center, NC Memorial Hospital

The first part of discussion can be summed up in a quote from one of the group members: "Health education cannot direct. It is a system of accomplishing people's needs and wishes, thus creating a state of well being." That was the basis for some of our thoughts. In fact, the whole theme of the discussion was that people are individuals; that we need to get to them in their everyday lives in the communities where they live. We then proceeded to develop a list of needs for health education. These are not in order of priority because we couldn't agree on priorities really. They are all important.

We need to train professionals to be conscious of the feelings and emotions of the consumer so that the latter can have a positive self-concept. In this atmosphere, education can then take place and, hopefully, a healthier population should result from that. We need to train people to feel that their health is their responsibility. We spent quite a bit of time talking about how to educate persons to be effective consumers. In fact, we would like to encourage the establishment of an agency at the federal level to deal with consumer problems as related to health services. We know there are

problems -- many people don't even know how to find their way into the system.

We felt that in each community there should be a single port of entry where everyone could find out about all the available health care. There were a number of suggestions as to where this might be: community places like the public library, a pharmacy, the churches, the schools. Here, people could get information on how to meet their health needs -- receive advice or be directed to treatment.

Health education should be a priority. We've heard that theme in almost everybody's talk here today. Budgets should include it and not just if there is leftover money. Agencies, insurance companies, and community resources could sponsor health counseling on specific topics. But, whatever we do, we should do as early as possible. We're talking about the kiddies in the pre-school, Head Start programs, and day care centers. We also felt we ought to get to the families. Family counselors do exist but we need more help in that area to show people how to incorporate health care into their daily living.

We had some further suggestions. We ought to require that all health clinics offer health education as a part of their services. Industries should increase utilization of screening and health education programs offered by various agencies. We should provide continuing education courses for adults on health. We should encourage the insurance companies to support even more health education. And finally, we feel that all the media should begin to put forth positive health education on all levels. We had many ideas expressed, but those are the major ones. We hope somebody out there is listening.

THE SUMMATION

" . . . a more realistic expectation . . ."

Summation

C. Arden Miller, M.D., School of Public Health, UNC-CH

We have heard excellent summations this morning, but I have some perspectives, particularly on the presentations of yesterday rather than the discussions that took place this morning, that I would like to share with you. Anyone who has participated in the sessions of the past two days cannot help but be impressed with the high quality of scholarship and thoughtfulness that has gone into them. They constitute a thorough and accurate representation of the health problems of the state and what we are doing about them.

A listener becomes immediately aware of the enormity of resources, concern, and anxiety that are going into a consideration of health and health services. But one is still left with the feeling that there is something of a riddle: what ought we to do about health services? That question allows many different answers. As a matter of fact, circumstances remind me of an old riddle that poses the question, "Why did it take four Boy Scouts to help the old lady across the street?" The answer is, "Because she didn't want to go!" We, as providers of health services, set about like Boy Scouts doing our thing in conscientious ways, with the most noble intentions possible, and in a spirit of unselfish helpfulness. But in fact, we do our thing with very little regard as to why we are doing it or where it is leading us. We provide very little involvement of the people we are trying to assist who could advise us of their goals, their needs, and their objectives. We listen very little to guidance on the circumstances under which we can most be helpful.

Strongly implicit in many of the presentations, from the Governor's on through those of the full two days, has been the feeling that if only we had

enough money, everything would be all right. And I'm not certain that is true; we just cannot accept it. Resources are limited, and I'm not sure that we have yet the wisdom and the courage to know what needs to be done and to do it. Can we really make wise and effective use of unlimited amounts of money?

Six or seven items stand out for our concern. These were matters that were touched on time and again by a number of speakers. The first has to do with priorities; the second with innovations; the third with accountability; the fourth with health education and behavior change for healthful purposes; the fifth with governmental responsibility; the sixth with some unresolved controversies -- we tended to skirt controversy in this conference, although many of the inputs are fair target for honest differences; and the last with an assessment of the conference itself.

Concerning priorities, I am enormously impressed that nearly all of our concerns, nearly all of our programs, and nearly all of our recommendations have to do with resource developments, inputs, and processes -- very little with outcomes. You know, we didn't really discuss what kinds of services we are trying to achieve and for whom. Somehow, if we drop enough manpower, enough money, enough hospital beds, enough something into the hopper -- out the other end will come everything everybody needs. And I don't believe that. It seems to me that in order to get some understanding of what kinds of resources we need, what kinds of money, what kinds of manpower, what kinds of planning, what kinds of regulation, what kinds of quality review -- we need to have some better understanding of what services we want and for what people.

The Governor came close to that kind of definition, though he didn't elaborate on it, when he closed his comments with the statement, "We can

make it possible for every person to get the health care he needs when he needs it." Now that's a pretty potent statement, and I hope he means it. I hope he means it about several concerns. I hope he means it with relation to the emphasis on needs. That to me means that conscientious and wise people, including consumers themselves, sit down and define needs; and those needs are not lost sight of under circumstances where only demands are responded to. The statement also suggests the Governor's willingness to make sure that when those needs are defined in terms of service outputs -- then they will be rendered to everyone. I hope he means that too. We don't yet have quite the mechanisms or the assurances to plan and render services according to need, but I think it's possible to do it and I hope the Governor expands that intent.

It's surprising that we haven't done more, particularly in this state, under the present administration which has given so much emphasis to management by objectives, to define service outputs for specified recipient populations. Objectives for health services need to be very well defined, and I don't think it's hard to do. If we were to try it, some of our problems might begin to fall away. Mr. Henderson came very close to addressing the problem of needs and service outputs when he couched so much of his presentation in an emphasis on simple, readily available services that reach everyone. This represents an important change in attitude, and I think a change very much in the direction we need to move. It's a change, interestingly enough, which has been adopted in some other countries to which we tried to give technical help for medical care in the past. For a long time, we tended to export elaborate technology to assist developing countries; and then it became clear that elaborate technology was soaking up an awful lot of resources and not helping very many people. Those countries which tended to do best in terms of health services were the ones that were able to emphasize

simple services of established value in a service system that reached everyone. Once those services were in place they could be built upon and upgraded. With those techniques, many countries with far less in the way of resources and commitment than we have, have been able to outstrip us in terms of improvement of health as measured by major health indices.

So an emphasis on outputs has been lacking from this conference. We have tended to dwell on kinds of manpower, payment sources, planning mechanisms, and hospital procedures as resources necessary to get some place that we haven't really defined very much.

With regard to innovations that have been presented, a number are tremendously challenging, important, and worthwhile. High among them must be the rural health clinics. They represent a real achievement in the state, not so much in terms of a system of care that will reach everyone who needs it but, as a model that gives high value to significant consumer participation and to local initiative. The rural health clinics may give less value and less importance than we need for communities and people who are so oppressed, so impoverished and so drained of initiative that they cannot act on their own behalf. These people are perhaps the ones who still are being overlooked. We need additional ways to reach them.

We have heard frequent mention in the past two days that there needs to be better public acceptance of new kinds of health providers: physician extenders, nurse practitioners, and people of this sort. The rural health clinics are a good example of effective use of nurse practitioners. I respond a little differently to the idea that consumers need to be better educated to use new kinds of providers. All the evidence I know suggests that consumers are very willing indeed to make use of them; I know of no circumstances where conscientious efforts have been made to use new kinds of

providers and where they have been rejected by consumers. But I know lots of instances where they have been rejected by traditional providers.

We need to examine this situation carefully, not only in relation to rural health clinics but with relation to Area Health Education Centers which represent another important innovation. Some inconsistencies about AHEC's perhaps should concern us. There are inconsistencies that one commentator identified relating to dental services: that restrictions on the participation of students and new kinds of providers in the AHEC program apply to dental care but not to other professional services. This circumstance suggests a professional narrowness that is not consistent with enlightenment that attaches to other parts of the program. AHEC's, I think, are an important and interesting idea -- an idea that will have payoffs that are really very long range. Mr. Ratliff, who said so many interesting and provocative things, described this as standing around, waiting to see the effects of AHEC.

I share a little of the feeling that we need some initiatives that are more immediate than waiting for new generations of students and new kinds of health professionals to come along with improvements that derive from their different kind of education. I bring some measure of skepticism to this approach as a result of years spent at the University of Kansas in the 1950's and 1960's. We didn't call our endeavors an AHEC program but it looked like one. All of our medical students were required to spend six to twelve weeks on preceptorship with a general practitioner in a small town in the western part of the state. Eight educational centers around the state provided continuing education courses by teams of faculty members from the University. We were doing many of the same things that are now more richly supported and promoted under the AHEC label today. Regrettably enough, after twenty years of experience with that program, Kansas found just as many

of their medical school graduates were practicing ophthalmology in California as had been true before. Reforms in medical education may not be able to counteract the pulls and pressures of our system of medical care. I think something else is needed. Educational reform may be a desirable initiative but not a sufficient one.

The new Planning Act is an innovation that received a lot of attention in this conference and deservedly so. Mr. Ratliff gave it ten years to survive. He introduces a skepticism that has some justification. If that Health Planning Act is captured by vested interests such as a dominating professional group, then it deserves to live much less than ten years. We cannot be absolutely certain that such a capture will not take place. To the extent that the new Planning endeavor can reach out to incorporate all kinds of health providers -- not just physicians but nurses and a whole host of providers; can give really significant participation to consumers; and perhaps most important of all can subject their planning functions to some real and legitimate public accountability at the local level -- to the extent that these innovations are incorporated in the new planning processes, then I think the new health planners can survive and make important contributions. But to the extent that planners deny that kind of accountability then Mr. Ratliff's ten years may be even more generous than the program deserves. The whole endeavor arouses fears in many minds that are associated with turning over public programs, public assets, and public planning to vested groups working in a nonprofit, corporate basis. One writer has called this, "government by nonprofit corporations." There may be some things that nonprofit corporations can do more effectively than government, but there are risks involved.

I want to give special emphasis to the innovation described by Mr.

Henderson on behalf of the twenty hospitals that expanded their emergency room services with thirty new physicians. It is an attractive and important idea but one to which some concerns attach. These will not be unknown to Mr. Henderson. Many people look to emergency rooms for their medical care, even though it is acknowledged to be at best a very inadequate, piecemeal kind of service. To the extent that we expand, fortify, and improve that kind of stopgap, piecemeal service, we may be putting off a more basic, fundamental kind of approach to comprehensive health services that some local health department or other public agency could provide. Emergency rooms need to be well-staffed and well-prepared to receive the many people who appear there; but we need to be careful that they do not become the kind of inadequate, incomplete, fragmented, half-baked health service program that we reserve for poor people.

Health service innovations in North Carolina offer considerable promise. They are a credit to many people. But so far they are not very basic to reaching everyone to meet needs when they need to be met. I hope the innovations expand. I hope that they do not become token showcase kinds of programs that bring much attention and credit to the state without really responding to the needs of the many millions of people who were so eloquently described in Mr. Esser's presentation.

Now, about <u>accountability</u>. This morning we heard a good summary on this issue so I will say only a few things concerning it. One relates to Peer Standards Review Organizations. The comment was made that PSRO's were enacted by a federal government that was really more concerned about cost containment than about improving the quality of care and that's exactly right. But within that concern about cost containment we need to bear in mind that there was legitimate fear on the part of federal agencies that they

were paying for an awful lot of unnecessary services. That's one kind of cost containment we should be terribly concerned about. When we are doing four to ten times as many tonsillectomies, when we are doing unnecessary hysterectomies, and when we see a shocking increase in the number of cesarean sections, seemingly for no other reason than that they can be paid for, there are reasons for very legitimate concern about cost containment. I hope PSRO's respond to those concerns.

Peer review suffers some of the same uncertainties as the new Planning Act. When we hear about peer review to assure quality, we may ask which peers are being reviewed. So long as there are not significant involvements of nurses, educators, special therapists, and a whole host of health providers in peer review mechanisms, we may wonder if physicians themselves have the wisdom to undertake the kind of quality review that will really best serve the full interests of patients. I am even more concerned if consumers are not involved. Consumers do have wisdom and insights to educate us about some of the inadequacies of our services. An accountability which excludes consumer participation is most incomplete and unsatisfactory.

I like Mr. Ratliff's recommendations about a grievance procedure to help patients with their concerns about hospitalization. I like his recommendation about a state health advocate's office. These concepts very much deserve to be developed further. I am involved in a related effort which is just getting started with some colleagues in Washington. Following a survey that we did several years ago about consumer attitudes toward health services, we are now attempting to put together a series of indicators about community health services that consumers themselves can develop in order to assess the adequacy of hospitals, local health departments, and other institutions and agencies of health.

The legislative initiatives suggested by Mr. Ratliff didn't include as much as might be appropriate around the growing affirmation that people have rights to services. You are familiar with court action in Alabama and in Washington, D.C., and action on behalf of handicapped children that begin to establish that there are rights to services, and that those rights are the responsibility of government to protect. Increasingly we need to recognize and define those rights and to assist their recognition and protection through governments at the state and local levels.

Government is becoming the "residual guarantor" for health services. We live in a pluralism of services in which market systems predominate, but a whole host of provider mechanisms are invoked. That pluralism is desirable, but it isn't going to protect anyone's rights. Unless there is some kind of a guarantee under that pluralism it becomes a kind of refuge behind which we continue to neglect large numbers of people. There is need for legislators to strengthen the role of state and local government as the residual guarantor for health services, on behalf of the populations within their constituencies.

Finally, Mr. Ratliff mentions, almost in passing, the concern about new legislation around the issues of the right to die. For many people medical technology has prolonged dying but not living. The Quinlan case brings into focus a problem we cannot ignore. The court in the Quinlan case resolved that specific issue in the only way possible. But the parents of that girl were asking a question of our society. That question is going to be asked over and over again, not only about whether or not people are really alive; but it's going to be asked about issues of human experimentation and genetic engineering. If society always answers these questions by saying, "Let the doctor decide," we do less than full justice. These problems represent some very basic moral and ethical issues that need to be addressed by churches,

educational institutions, legislators, and a whole host of organizations. We need to come up with some new guidance for medical technology. Perhaps a blue-ribbon commission at state and community levels could assist in arriving at that kind of guidance. If society always allows the doctor to decide these difficult ethical issues, he can decide them only in one way. That is the way which will allow medical technology to dominate humankind, rather than allowing people to dominate medical technology.

The environmental presentation was an important one, but it lacked the kind of firm definition of public responsibility that circumstances require. A facetious sense of humor suggests piping the air from smoke stacks into meeting rooms of boards of directors. Far more realistic is to demand of industry the kind of accountability that the law requires and which we have been remiss in enforcing.

We continue to see the splintering off of environmental, regulatory, and enforcement agencies into separate organizations that know little about health and have even less concern for it. Even worse, they are splintered and often turned over to people who are themselves the worse polluters of the environment. It's a circumstance of "the fox watching the chicken house." If there were ever a need for an aroused and informed public to insist on public accountability, then indeed, this is it. Environmental protection is a perfectly legitimate and important way in which consumers should be well-informed and given the expertise and resources to act effectively.

Mr. Henderson, in other terms of accountability, give quite appropriate emphasis to the long lack of public accountability in medical education and the discovery of new responsibilities by medical schools. Mr. Ratliff expanded that concept in a way we should not overlook. I think it's not just medical schools that need to be more accountable. It is all of our

institutions and agencies of health. They need to be increasingly accountable not only to the people who are working in them, but to the people who are receiving their services. One after another of our institutions and agencies of health service regards itself as accountable to its own professional group. It's nonsense. We must devise ways in which these agencies, whether they be health departments, nonprofit insurance companies, HMO's, or planning agencies, are accountable to the people who are supposedly to be the recipients of their services.

Now, a word about the emphasis we have heard on behavior change through education -- in some ways it is the theme which has been most conspicuous of all in this conference. There is much that medical care can't do to help people who will not behave themselves and act better in the interest of their own good health. We must exhort them to healthy behavior. It's almost as if we don't already have an overwhelming kind of health education going on in the country everywhere right now. It is a kind of health education that is, in most ways, counter-productive -- health education in which television sets, billboards, and magazines constantly blare out information about junk foods, consumption of alcoholic beverages, and use of tobacco. The kinds of behavior that we think are least in the interests of the public are constantly encouraged by public educational programs called advertising, and that are just as effective as they can be. I am not encouraged that we can couteract all of that pressure for behavior change by flimsy programs of health education.

We must recognize that our public is being educated in counter-productive ways about health and unless we control that kind of education our mission is hopeless. The techniques are not hard to devise. An advertiser who is exhorting behavior change which is known to be detrimental to health could

be taxed so that for every dollar he spends on advertising his own junk foods, he must deposit another dollar in a trust fund to be used for educational purposes about effective nutrition.

The other thing that concerns me about efforts to change people's behavior through education is how often we exhort people to change when they don't really have the resources to do it. This is seen in relation to the problems the state faces about nutrition. The view prevails that if we could only teach people more about what they ought to eat, they would be all right. Again, it is nonsense. Evidence confirms that people already know vastly more about nutrition than they are able to put into practice. If they don't have the resources to change, then it is cruel to advocate it. The best remedy for inadequate diets is enough food. The best remedy for a number of health problems is enough money -- not money spent in our own professional ways but money spent by poor people. The evidence is pretty good that if we gave more money to poor people they would be healthier.

More needs to be said about governmental responsibilities for health. The Governor introduced this concept when he said, "There are some areas in which government would be failing the people if it did not attempt to seek solutions to their health problems." He is exactly right and it is important that government not fail people by failing to address those issues; but I wish the Governor had gone on to identify what they are. There are indeed responsibilities of government for health; they are largely neglected through lack of definition. It is time to define them and it should not be a difficult job.

One of the responsibilities is to see that there is an adequate distribution of resources and services. We continue for the most part to give

health services largely to people who are least at risk. We provide some correction through rural health clinics but there are many high risk populations who are not reached. Among them are the very old, the very young, and the economically or racially deprived. It is these people for whom government must carry unique responsibility to provide an equitable distribution of resources and services.

Mr. Ratliff was exactly right when he reported that state and local government have a unique responsibility to provide services which federal government cannot provide. These have to do with enforcement and regulation invoking authorities and powers that are vested in local and state government and not in federal government. Federal government does not have police power; just look at the difficulty we get into when the FBI and the CIA attempt to take over police powers that ordinarily are restricted to local government.

With regard to another issue about governmental responsibility, I want to refer to Mr. Henderson's claim that primary health care is largely a matter of free enterprise. He urged that efforts to expand and extend primary services be done in such a way that private providers find it acceptable. I find that formulation not acceptable. I really don't see what is so free nor what is so enterprising about a service endeavor which, in order to survive, must be so richly subsidized, so carefully planned from public sources, and for which manpower must be trained in expensive public institutions. To place such an endeavor in a free enterprise context, shielded from public influence and control, is unfair. Furthermore, it does less than full justice to the tremendous amount of primary care that is rendered by public agencies in our state. Sarah Morrow, you must have cringed. I know the superb kind of primary care clinics the Guilford County Health

Department offers. I know that some years ago when you began your Children and Youth Project, you were able to establish that there were something like 18,000 children in Greensboro who were totally ignored by the free enterprise system of health care. They are getting pretty good care now and they are getting that care through a public, tax-supported, local, governmental agency. I think this entire conference has neglected consideration of public agencies, of local health departments, and of public responsibility for health and health services to an extent that I find disturbing.

In terms of occupational health, again it seemed to me that less than full justice was done to the matter of public responsibility. I just cannot accept, as was suggested, that occupational safety and health are matters to be negotiated between labor and management. They are matters to be regulated, monitored, and controlled by government. There is a public responsibility to make certain that workers are protected and that they work under safe circumstances. The profit incentives of our economic system are so strong that we just cannot expect industry voluntarily to guarantee that the worker's interests are protected. That kind of protection is government's responsibility. I am aware of the claim that the inspection of workplaces for safety and health represents such an overwhelming problem that we cannot provide enough inspectors to make certain that all codes and regulations are obeyed. If that is true, then workers must be educated to serve as inspectors of their own workplace. Workers need channels of reporting so that flagrant abuses of regulations can be promptly brought to the attention of reponsible public authorities. The emphasis was made this morning that those authorities ought to be local health departments. That is true, in a sense, but we must introduce a caution that local health departments, though they have a great unfulfilled potential to do far more than at present, are also tremendously

vulnerable to local pressures and influences. It is going to take an extraordinary health department to confront an industry that is the core of the local economy in a way that will command compliance. If we are going to go that route, and much recommends it, then local health departments will need a lot more backup and support from state authorities than is sometimes given.

Assuming that all of you agree with all these perspectives, I will go on to identify some controversies that were touched on and not developed as fully as they might have been. One was Mr. Rose's formulation about how resources have alternate uses and they must respond to the wants of the people. That's the kind of formulation that is not sufficient for our purposes. In our society, some people are more effective in drawing attention to their wants than other people. Some wants are artificially generated through advertising. If allocation of health resources is left on such a laissez faire basis, we neglect basic responsibility of government to provide guarantees to meet needs. Mr. Rose gave appropriate attention to nonmedical determinants of health -- smoking, alcohol consumption, physical inactivity, social pathology, psychological problems, highway accidents -- and I agree with all that. But I don't agree that we should blame the victims of these disadvantageous circumstances and I don't agree that we need to be so helpless about them. We can control advertising that fosters poor health practices. We can tax certain items, maybe alcohol and cigarettes, so heavily that only a very few people would be able to indulge themselves destructively. Mr. Rose, himself, can adopt some practices that would be constructive in addressing nonmedical determinants of health. Why doesn't Blue Cross give premium rebates to nonsmokers? They are not going to get cancer of the lung nearly as often. Why doesn't Mr. Rose give premium rebates to teetotalers? They will live longer and become involved in fewer

crippling accidents. Why doesn't he give premium rebates to safe drivers? They are not going to end up in the emergency room and they are going to be less expensive to his insurance company. Why doesn't he give premium rebates to women who receive adequate prenatal care? Or to children who are fully immunized? There are many things he can do to influence nonmedical effects on health. To pretend that we don't know how to cope with these matters does poor justice to our resourcefulness, and probably ignores other potent constraints.

Mention was made, almost in passing, of an important matter of controversy that ought to be explored perhaps at another time. It had to do with Mr. Rose's allegation that if we had national health insurance, or any device that eliminates the financial barriers to health services, that we would have long lines of people waiting to see the doctor. There is no evidence to support that claim. People have better things to do than sit in the doctor's office unnecessarily. If there is evidence that removal of financial barriers to health services produces an overburdening utilization, we should see it. I've not seen it and I've looked for it. On the other hand, I have seen evidence of what happened in Quebec when all medical care became free. There was only about a 2% change in the utilization of doctors' services and that change was on behalf of people who ought to have seen a doctor sooner than they had previously. There was negligible unnecessary or inappropriate utilization.

The claim was also made that we need to be careful because "rising medical costs make government-financed programs more costly for the taxpayer." I'm not sure I know what that means but I don't want it to go unchallenged. Rising medical costs will make medical care programs more expensive no matter how they are paid for. Is it not legitimate for the

public to decide how they wish to pay for their medical bills? Taxes, insurance, or fee-for-service are matters for the public to decide and not for the professions or insurance companies to dictate. Attempting to influence that decision by claiming that a public mechanism of payment is more expensive than private payment is on very tenuous ground. We should see that evidence. I know of no firm evidence that payment of medical expenses through tax procedures raises the cost. I do know some evidence that paying for medical expenses through private intermediaries increases the cost because their administrative costs have increased by about 75% since Medicare.

I want to say a word about the important concerns, very properly expressed, by Mr. Vitaglione, on family planning and population services. I certainly agree that this state needs to give increased support and increased attention to that difficult problem. There are some problems that were not fully dealt with in our conference. They are being dealt with on a national basis in ways that we need to pay attention to. There are many poor people and many ethnic minorities who believe that many of our programs -- family planning, population control, and sterilization -- are used in oppressive ways that violate personal rights and in ways that may be genocidal. If you don't believe that, it doesn't absolve you of responsibility to answer the charges adequately and I don't think we do a very good job in answering. It becomes increasingly difficult for me to espouse family planning and sterilization programs without more in the way of protection of rights than we have written into such programs so far.

Finally, a word about the conference itself. I thoroughly enjoyed it. I found it informative. I enjoyed seeing friends. There was very little discontent among us. Were we a little self-congratulatory about things we have done? I would like to have seen a little more vigor and a little more

inspiration focused on aspirations for additional things this state might do because I think that we can do so much more. We are very decent people helping each other to help a few people. We tend to be Boy Scouts helping the old lady across the street without knowing fully what whe wants and where she wants to go. I'm a little discouraged that we, as a group of professional people, may not yet be sensitized and not yet sufficiently aroused by the data George Esser presented.

In essence, I feel that those of us who have met here in the past two days don't really represent the mainstream of concern about health and health services. I miss the poor people. I miss the union representative. How can we talk about occupational health without hearing from organized labor? How can we talk about environmental protection without hearing from the conservationists? How can we talk about poor people and what they need without hearing from them?

If we are to have that kind of a meeting, we might expect voices to be raised. Confrontations and controversy might develop and we might face embarrassments. We need them terribly. It is a shame for us to be quite as placid as we have been for many reasons. People who are the recipients of our services have much to say about how those services are rendered and what they will be. We have talked about changing the consumer's behavior through health education as if he were the passive recipient of whatever we want to do to him or for him. In truth, the real health education that needs to be done in this state, and I think in this country, is health education of us, the medical providers, by the consumers. We have missed that terribly in this conference, and I hope it can be corrected in another.

Thank you very much.

Closing Remarks

David G. Warren, President, North Carolina Health Council
Duke University

Thank you very much, Arden Miller. That was provocative, stimulating, perceptive -- and on time. I think by the applause from the audience you know that you were making sense to everyone here. We all appreciate that.

On behalf of the North Carolina Health Council and the Office of Continuing Education in Health Sciences at the University of North Carolina, I wish to thank the Kate B. Reynolds Health Care Trust for supporting this first North Carolina Health Convocation. I wish to thank all of you also who have been participants. And especially, I wish to thank those elected officials who were able to attend. Among the audience were legislators, county commissioners, mayors, and others who ultimately have the responsibility for determining public policy in the area of health as well as in all the competing areas. I think that it is very beneficial for us to sit together with public officials, in settings that are mutually amenable to discussion, to deal with these matters and to resolve them.

I believe it has been an exciting and serious event, this first Health Convocation, producing many new ideas and much good will, if not embarrassment, as Arden Miller suggested it should have. I think that the North Carolina Health Council's mission has been reinforced by this convocation. It has provided a friendly and neutral forum which can, if repeated, produce the kind of amicable conflict that can get to the truth of matters. The convocation has brought together many diverse and varied health organizations, though not all of them, to jointly study problems, to foster mutual interests, to develop new alliances, and to stimulate the future cooperative effort that I alluded to yesterday when I pointed out what we thought the hopes and goals

of this convocation were.

Infact, I am delighted to report that last evening the North Carolina Health Council took action to begin planning for a second North Carolina Health Convocation next year. Miss Emma Carr Bivins is Chairman of the Health Council's Planning Committee and will work on preparations with Ralph Boatman. I trust and hope that those of you who attended this convocation will have ideas and suggestions for 1976 and will in fact attend, along with the many others who were not here this time.

Thank you all for coming, and I will see you next year.

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"... from all parts of the state and from a diversity of backgrounds ..."

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